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Rebekah Reysen
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# Journal of Counseling Research and Practice

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Rebekah Reysen, Ph.D., NCC, LPC, DCC
rhreysen@olemiss.edu
Assistant Director of Academic Support Programs & Adjunct Assistant Professor
Center for Student Success & First-Year Experience
The University of Mississippi
+1 (662) 915-2352

# *School Counselors Applying the ASCA 2016 Ethical Standards*

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**Glenda S. Johnson**
*Appalachian State University*
**Josh C. Carrico**
*McAlpine Elementary School*

**Abstract**
As the student population becomes more diverse in the United States (Human Rights Campaign, 2018; National Center for Education Statistics, 2018), school counselors (SCs) are also called upon to provide comprehensive school counseling programs to meet the needs of all students (ASCA, 2019). In addition to following the profession's national model, the American School Counseling Association's Ethical Standards (2016) provide a set of guidelines including specific language aimed at providing culturally competent counseling services to students and stakeholders. With this in mind, the purpose of this manuscript is twofold. The first goal is to provide SCs with strategies for use when providing services to diverse students. Next, the authors will highlight sections of the ASCA Ethical Standards for School Counselors (ASCA, 2016) that specifically address diverse students' needs. Case scenarios will also be provided.

As the U.S. population becomes increasingly diverse (U.S. Census, 2014), so does the P-12 student population. Therefore, it is becoming more and more imperative for school counselors (SC) to provide culturally competent counseling services to this rapidly evolving diverse student population. Cultural competence, as described by Ball et al. (2010), is "knowledge and skills related to practice that value diversity and reflect effective practice across cultures" (p. 121). Through various accreditation (e.g., Council for Accreditation of Counseling and Related Education Programs [CACREP]) and special recognition preservice programs (e.g., American School Counseling Association Specialized Professional Association (ASCA SPA), SCs are trained, to provide these services. Additionally, the American School Counselor Association calls upon SCs to implement a comprehensive school counseling program (CSCP) using the ASCA National Model (2019). Coupled with ASCA's National Model, SCs are ASCA's Ethical Standards for School Counselors (ASCA, 2016), which include mandates for SCs to provide counseling services to students, teachers, parents, and

Correspondence concerning this article should be addressed to Glenda S. Johnson, Appalachian State University, RCOE 151 College Avenue, Boone, NC 28608. Email: johnsong@appstate.edu

other stakeholders with a focus on consideration of diversity. Keeping these resources at the forefront, the purpose of this article is twofold. The first goal is to provide SCs with culturally competent strategies from the literature to inform the implementation of their CSCP. Secondly, the goal is to highlight sections of the ASCA Ethical Standards for School Counselors (ASCA, 2016) that intentionally focus on providing culturally competent counseling services to students and stakeholders.

The student population in the United States continues to increase in diversity (Human Rights Campaign, 2018; National Center for Education Statistics, 2018; National Center for Children in Poverty, 2019). For example, regarding race, the Hispanic student population is the fastest-growing population in the U. S. (U.S. Census Bureau, 2016). Additionally, the number of youths who identify as lesbian, gay, bisexual transgender (LGBTQ) continue to grow in the U.S. (Human Rights Campaign, 2018). The number of students receiving special education services under the individuals with disabilities act (IDEA) decreased from 13.8 (2014-15) to 13.7 (2017-19) (NCES, 2020). However, there was an increase in students (1.5 percent) receiving accommodations under Section 504 (The Advocacy Institute, 2015); thereby, resulting in an overall increase in the number of students identified as having a disability. A look at the statistics of these identified groups of students provides a glimpse of the diversity in U.S. schools today. With a CSCP in place, which includes following the profession's ethical standards, school counselors can provide services to all students regardless of their diversity (ASCA, 2019; ASCA, 2016).

## Comprehensive School Counseling Programs

The four components of a CSCP include define, manage, deliver, and assess (ASCA, 2019). Specifically, the deliver section consists of SCs providing classroom instruction, small group counseling, individual counseling, planning, appraisal, and advisement, consultation, collaboration, and referrals (ASCA, 2019). One delivery method designed to reach all students is providing classroom instruction. School counselors present and/or work with teachers to deliver classroom instruction lessons. In order to teach culturally competent lessons, the astute SC knows the various cultures represented in their current school population. This is indeed a daunting task for a variety of reasons. For example, some differences are not visible, revealed, or regarded as a difference. Completing a school diversity document, reviewing data, and administering anonymous surveys, as well as communicating with teachers, faculty and staff, and parents are some of the various ways SCs can learn about the differences among their students. After obtaining this information, planning classroom lessons with an intentional focus on inclusiveness transforms an ordinary lesson into a lesson that is culturally sensitive. Additionally, knowledge regarding students' cultures can assist SCs' work when delivering services such as small group counseling, individual

counseling/planning, and consultation. Using the profession's ethical standards as a guideline can provide additional direction when providing both direct and indirect services to students and parents.

## American School Counseling Association's Ethical Standards

"Professionalism means knowing your professional association's ethical standards and adhering to them" (Stone, 2017, p. 27). Although the focus of this article focuses on the ASCA ethical standards for SCs, SCs have at their disposal numerous professional, ethical standards and competencies that provide guidelines for delivering culturally competent services. For example, the American Counseling Association's Ethical Standards (ACA, 2014) emphasizes the importance of counselors incorporating consideration of the clients' culture throughout their standards (Section A: The Counseling Relationship; Section B: Confidentiality and Privacy; and Section E: Evaluation, Assessment, and Interpretation, ACA, 2014). More specifically, ACA provides numerous competencies to govern services provided to diverse groups (e.g., ALGBTIC Competencies for Counseling LGBQIQA, Competencies for Counseling the Multiracial Population). School counselors can familiarize themselves with and adhere to these competencies by frequently reviewing them.

Specifically, SCs adherence to the ASCA ethical standards begins with the Preamble that state SCs have the responsibility to provide students with their inherent rights. Regardless of students' cultural differences, those rights include treating students with respect, dignity, and equal access to a CSCP (ASCA, 2016). Additional culturally relevant sections of the ASCA 2016 Ethical Standards address SCs responsibilities to students, parents/guardians, school, and self. Specifically, concerning students, SCs have a responsibility to (a) respect both their student's and family's values without imposing their own, (b) provide career counseling strategies based on data used to identify gaps and prevent biases, and (c) continuously demonstrate the utmost respect for student diversity (A.4.c. & A.6.e.). School counselors' responsibilities to parents/guardians include sensitivity to and respect for the diversity among families (B.1.d.). Furthermore, SCs have a responsibility to their schools to (a) design and deliver a CSCP that supports and further improves the academic learning of the entire student body regardless of diversity (B.2.b.), (b) use language that is culturally inclusive in all types of communication (B.2.p.), and (c) promote a school climate that acknowledges and celebrates diversity (B.3.k.). Lastly, SCs have a responsibility to actively monitor and further their social justice and advocacy awareness, knowledge, and skills (B.3.k.). All school counselors, as professionals, are to follow the ASCA Ethical Standards for School Counselors, regardless of their organizational membership to the ASCA (Stone, 2017). Some of the ways school counselors can remain abreast of the profession's cultural competency standards include attending

ongoing ethical professional development and setting aside a monthly time to review the standards in their entirety. All students and stakeholders would benefit from school counselors' adherence to these standards that provide guidelines for addressing the counseling needs of diverse student groups.

## Diverse Students

The ASCA Ethical Standards identifies 17 different student populations that could exist within the school setting. The list includes, but is not limited to: "... ethnic/racial identity, nationality, age, social class, economic status, abilities/disabilities, language, immigration status, sexual orientation, gender, gender identity/expression, family type, religious/spiritual identity, emancipated minors, wards of the state, homeless youth and incarcerated youths ..." (ASCA Ethical Standards for School Counselors Preamble, ASCA, 2016, p. 1).

It is not within the scope of this manuscript to cover information on all of the aforementioned groups. Nonetheless, the authors believe that the information provided for some of the diverse groups will assist school counselors in their work with all diverse students in their schools. To that end, (a) information, (b) strategies, and (c) ethical dilemmas are given for the following groups:

1. Ethnic and racial identity,
2. gender identity and expression,
3. disability, and
4. economic status.

This article contains possible answers to the ethical dilemmas at the end.

### Ethnic and Racial Identity

As previously stated, a variety of differences exist among students in today's schools. One of those differences is the often visibly identified student's race. Physiological differences that a group of persons share is the definition of race (Merriam–Webster Dictionary, 2019). Race, according to the U.S. Census, is broken down into the following categories: (a) White or Caucasian, (b) Black or African American, (c) American Indian, (d) Alaska Native, (e) Asian, (f) Native Hawaiian or Other Pacific Islander, and (g) Some Other Race. Currently, the majority race in the United States is White. However, the Hispanic student population is increasing (U. S. Census, 2016). Therefore, our student population is becoming increasingly more diverse. Currently, the majority of school counselors are White, followed by African Americans (Data USA, 2019). Interestingly, a review of the literature reveals a possible lack of racial sensitivity in White school counselors (Moss & Singh, 2015). Compounding this is the power differential between White SCs and students of color that could impede minority students' access to a variety of supports (Moss & Singh, 2015). This could also limit advocacy efforts on the part of their SCs (Parikh et al., 2011) when compared to the advocacy efforts afforded their White peers. Additional disparities have been noted in the area of college counseling, with White counselors recommending postsecondary higher

education to White students as opposed to African American students (Groce, 2012). Lastly, Chao (2013) found that limited multicultural training and higher color-blind racial attitudes in preservice counselors led to low scores in the area of multicultural competency. The following is a list of strategies SCs and preservice SCs can use to provide culturally competent strategies to students of color.

***Strategies***

School counselors can use various strategies to address cultural competence when providing services to students from minority races/ethnic identities. First, they can seek multicultural supervision. West-Olatunji et al. (2011) found that although school counselors felt they received adequate multicultural education in their preservice programs, participating in advanced multicultural supervision enhanced their ability to provide culturally competent services to parents and students. Participants, practicing school counselors, participated in nine supervision sessions led by a counselor educator. These sessions included activities such as (a) reading of culturally relevant journal articles, (b) exploring case examples, and (c) processing of the case examples (2011).

Additionally, school counselors can (a) engage in mindfulness training specifically focusing on "mindfulness nonreactivity to inner experiences" and "mindfulness describing" (Ivers et al., 2014); (b) become aware of one's own biases, stereotypes, and personal beliefs that may interfere with duties as a school counselor and being able to set them aside (Fisher, 2008; Stone, 2017); and (d) immersing oneself in another race's community for a period followed by engaging in reflection and dialogue, and paying close attention to the emotions experienced (McDowell et al., 2012). The strategies mentioned above can improve school counselors' skills in delivering culturally competent counseling services to racially/ethnically diverse students.

**Ethical Dilemmas.**

1. Damian, an African American, 11th-grade student, requests to visit with his White school counselor, Mrs. Camp, regarding his postsecondary plans. Before calling the student to her office, Mrs. Camp reviews Damian’s records in the student electronic database. This information includes his race, parental information, address, attendance, grades, standardized tests, discipline records, and more. Based on this information, Mrs. Camp decides to recommend that Damian forego a postsecondary education and seek a position at the local distribution center. She plans to share with him that the salary is above minimum wage, and the company offers some benefits.

2. Angelica, a Latina female, is in the second semester of her junior year. She requests to see her counselor, Mrs. Brown, who is African

American, regarding her postsecondary options. Angelica desires to attend college after high school. Through her research on the local industry, Mrs. Brown is aware of the need for persons who are Latino and are fluent in Spanish. Although Mrs. Brown does not know if Angelica speaks Spanish, she assumes she does so based on her race. Therefore, she plans to meet with Angelica and share her excitement regarding Angelica's opportunity to obtain meaningful employment immediately after high school graduation.

**Gender Identity and Expression**

Although the lesbian, gay, bisexual, transsexual, queer, intersex, asexual, and pansexual (LGBTQIAP+) population is referred to as the invisible minority, approximately 10 million individuals identify within the community and the numbers continue to grow (Weinberg, 2009). With this in mind, in 2017, 6,252 youth between the ages of 15-24 died by suicide (American Association of Suicidology, 2019). While it is unknown how many of these youth identified within the LGBTQIAP+ community, as current death records do not include the deceased's sexual orientation, it is known that LGBTQIAP+ youth are almost five times as likely to attempt suicide compared to heterosexual youth (Kann et al., 2016). Therefore, the need to provide counseling services for this diverse group is of utmost importance.

A review of the aforementioned statistics illuminates the importance of SCs preparation to provide culturally responsive services when working to eliminate barriers that may hinder LGBTQIAP+ students' development. The following strategies are provided to assist SCs with addressing the unique needs of this population.

***Strategies***

In terms of interventions, first and foremost, SCs can become aware of and professionally set aside their own biases, stereotypes, and personal beliefs that may interfere with their duties as a school counselor (Stone, 2017). They can also stay current on relevant information regarding state policies and legislature on anti-bullying and nondiscrimination laws (Dunnell, 2018; Human Rights Campaign, 2018). Importantly, SCs can focus on improving the school climate by providing professional development for staff on LGBTQIAP+ topics, such as how to respond when discrimination, harassment, and bullying occur (Payne & Smith, 2018). Additionally, SCs can provide Campus Pride groups and SGAs to promote inclusion (Walsh & Townsin, 2018);
and, provide positive messages and displays about the LGBTQIAP+ community within the school (Dunnell, 2018; Human Rights Campaign, 2018).

**Ethical Dilemmas.**

3. Mrs. Windham is the school counselor at a local high school. A

concerned student reported to her that her friend, Latisha, just came out to her parents. Afterward, the parents rejected Latisha and asked her to leave their home. She is now living on her own under a bridge close to the school. When approached, Latisha requested confidentiality in this matter because she does not want to risk moving and losing her connections to her friends. The SC is afraid of losing her trust if she reports personally identifiable information to the local homeless liaison officer.

4. A teacher expresses to the SC that they are upset with the administration within their role as the school's Gay-Straight Alliance Club (GSA) faculty advisor. The teacher submitted an order for members' cords to wear during the graduation ceremonies. The principal, however, did not approve the GSA's order and canceled it at the last minute. Nonetheless, the principal ordered all the other campus clubs' cords. The teacher expressed that the principal has shown prior resistance to the GSA's activities, and the teacher feels that, as opposed to an error, this was a personal decision to cancel the cords. The teacher requested the SCs assistance in the matter, stating that the principal will not listen to the club's sponsor. How should the counselor address the principal?

**Disability**

Many students in public schools today have a disability and fall into two classification groups. The first group, identified under the Individual with Disabilities Act (IDEA) amended in 2015 through the Public Law 114-95 the Every Student Succeeds Act (IDEA, n.d.,) are the largest. Unlike the previous categories mentioned (i.e., race/ethnicity, LGBTQ), the percentages of students in this category slightly decreased from 13.9 in 2014-15 to 13.7 in 2017-18 (NCES, 2020a). These students fall into 13 disability categories: autism, deaf-blindness, deafness, emotional disturbance, hearing impairment, intellectual disability, multiple disabilities, orthopedic impairment, other health impaired, specific learning disability, speech or language impairment, traumatic brain injury, and visual impairment (NCES, 2020b). Students receiving services under IDEA require, among other rights, an individual education plan (IEP) outlining their specific needs and the stakeholder who will provide those services. School counselors are often one of those service providers (Nichter & Edmonson, 2005). Additional students identified as having a disability fall under Section 504.

Section 504 of the Rehabilitation Act of 1973 (The Advocacy Institute, 2015) is a law that requires students who qualify to receive accommodations to level the playing field in order for them to access education. This group of students comprises 1.5 percent of the student population (The Advocacy Institute, 2015). A team of stakeholders is

required to identify these students and develop an individual accommodation plan to meet their needs. School counselors are often a part of this multidisciplinary team or often coordinate this process (Goodman-Scott & Boulden, 2020; Romano et al., 2009). Additionally, they are often required to provide both direct and indirect services to students and stakeholders. Unlike special education teachers who receive training to provide specialized education to students with disabilities, general education teachers and SCs may or may not have received similar training in their preparation programs. Therefore, SCs may feel ill-prepared (Goodman-Scott & Boulden, 2020; Romano et al., 2009) to provide counseling services to students with disabilities as well as collaborative services to teachers and parents. Nonetheless, both legally and ethically, they are required to provide services to students with disabilities and stakeholders as part of a comprehensive school counseling program (ASCA, 2019, ASCA 2016, Buckley, & Mahdavi, 2018). School counselors can employ culturally relevant strategies to provide services to students with disabilities in their schools.

### *Strategies*

As part of a comprehensive school counseling program, SCs can provide both direct and indirect services to students with disabilities through a variety of interventions. For example, in the academic area, SCs can provide classroom lessons, psychoeducational groups, and individual counseling on study skills, organizational skills (Buckley & Mahdavi, 2018). Additionally, in collaboration with teachers, they can assess whether the environment, curriculum, and instruction are appropriate for the learner (Grothaus, 2018). In the domain of social/personal growth, SCs can provide short-term counseling (individual or group) to address targeted areas such as self-awareness, self-concept, identifying strengths, resilience, and transitioning to the next grade level or postsecondary careers (Buckley & Mahdavi, 2018).

**Ethical Dilemmas.**

5. Mrs. Rosario, a tenth grade English teacher, approaches the SC, Mrs. Flint, about a few of the students who identified as having a learning disability in her classroom. The teacher shares that the students receive support from the special education teacher; however, they are falling behind in their grades in most of their subjects. The SC shares with the teacher that students who are receiving services under IDEA have their own special education support teachers and counselor. The SC refers Mrs. Rosario to seek assistance from the special education department.

6. A parent, Mr. Engels, schedules a visit with the SC, Mr. Henderson, to discuss his daughter. Mr. Engels' daughter, a third-grader, is a student identified as having attention deficit hyperactivity disorder (ADHD) and receives accommodations under a Section 504 plan. The SC meets with

the parent for a consultation session. Mr. Engels shares that although the teacher shares that his daughter's grades are improving due to the accommodations, his daughter shared with him that she is feeling different and singled out because the other students are aware of the special accommodations she receives. Mr. Henderson did not receive training in his preservice program and is scrambling for ways to respond to the parent. He shares with Mr. Engel that he will speak with his daughter's teacher and follow-up with him.

**Economic Status**

Students living in poverty face a unique set of challenges that vary from their more affluent peers (Odgers, 2015). Some of those challenges include a lack of adequate shelter, food, and clothing. Yoshikawa et al. (2012) shared that absolute poverty has a causal effect on children's' mental, emotional and behavioral health. The authors define absolute poverty as an inability to meet the most basic needs. Approximately 21% of children in the United States live in poverty (National Center for Children in Poverty, 2019). School-aged children living in poverty bring unique sets of circumstances to our schools every day that can affect their academic preparation, in addition to the aforementioned areas (ACT, 2015; Odgers, 2015).

A school counselor's mandate is to provide services to all students regardless of their economic status. Notwithstanding, providing services to students living in poverty can be a challenge to the most astute school counselor. The roles of advocacy (Stone, 2017), leadership (Johnson, 2017), and change agent (Schnenck et al., 2010) are especially useful to address circumstances that prevent school counselors from providing needed services to such a vulnerable population as children living in poverty. In addition to the roles school counselors employ, they can incorporate the following strategies when working with students from lower economic households.

***Strategies***

School counselors can use different strategies to provide counseling services to students from lower economic backgrounds. For example, SCs can begin with recognizing and addressing any biases or preconceived notions toward students living in poverty. Additionally, they can build meaningful relationships with students (Williams et al., 2015) whereby, allowing them to identify and expand students' strengths (Foss et al., 2005). School counselors can involve teachers as a valuable resource who can assist in providing services to students (Au, 2013; Johnson, 2017; Newell, 2013). Furthermore, they can cultivate a collaborative, supportive role with parents (ASCA, 2016; Johnson, 2017), and work with community agencies to identify those organizations that can provide needed resources to students and their families (Johnson, 2017).

**Ethical Dilemmas.**

7. Yusef, a middle school student, is struggling in reading and math. Both of his teachers have submitted a referral to the school counselor for academic advising. The school counselor schedules an individual planning meeting with Yusef. During the meeting, the counselor realizes that Yusef could benefit from tutoring in both subjects. She provides Yusef with referrals to neighboring organizations that offer tutoring for a fee in the community to share with his parents. The student informs the school counselor that his parents are not able to pay for tutoring services for him. Empathically, the school counselor shares that, unfortunately, the only agencies providing tutoring services in the community charge fees.

8. A ninth-grade school counselor, who works at a school in which 95% of the students receive free and reduced lunch, is planning a parent workshop on the benefits of obtaining a postsecondary education. The workshop will take place on a Wednesday evening at 5:00 p.m. Several parents contact the school counselor and expresses their interest in attending this important workshop but share that they lack transportation and childcare for their younger children at that time. The school counselor tells the parents that, although she understands their barriers, the workshop schedule will remain. She explains to her administrator that she must arrive at the daycare before it closes at 6:30 p.m. to pick up her own young children. There was a dismal turnout at the workshop.

## Summary

The student population in the U.S. is becoming increasingly diverse (Gallo, 2014; National Center for Education Statistics, 2018; National Center for Children in Poverty, 2019; U.S. Census, 2014). With this increase in differences among our student body comes the necessity to meet their ever-increasing needs (Davis et al., 2011; Groce, 2012; Yoshikawa et al., 2012). School counselors are well suited to meet the needs of all students through their implementation of a CSCP (ASCA, 2019). They can improve their cultural competency skills through implementing a CSCP for all students (ASCA, 2019), following the professions' standards (ASCA, 2016), seeking multicultural supervision that involves journal readings, case conceptualizations, and processing (West-Olatunji et al., 2011), and by participating in professional development on the topic of cultural competency (Davis et al., 2011).

Within the supervisory relationship, both the supervisor and the supervisee play a role in developing and maintaining the relationship. However, supervisors are oftentimes the facilitators and have more responsibility in ensuring the effectiveness and constructiveness of the interaction

(Benard & Goodyear, 2014). For example, counseling psychologists have spent time creating guidelines for clinical supervision due to supervisees in training programs reporting their supervision is harmful and inadequate (Ellis et al., 2014). So, a supervisor's proficiency in facilitating supervisory duties directly impact the health of the relationship and one such skill that is needed is multicultural proficiency (Crockett & Hays, 2015; Lee, 2017). Researchers have argued that a supervisor's level of multicultural proficiency can affect the quality of functional cross-cultural supervision (Crockett & Hays; Inman, 2006; Sue & Sue, 2008). Supervisors who exhibit a high level of multicultural awareness encourage minority supervisees' self-disclosure (Sue & Sue, 2008). Crockett and Hays (2015) also highlighted that the level of multicultural competence supervisors self-perceive is closely related to the development of counseling self-efficacy and supervisee satisfaction of the supervisory experience. In addition, a supervisor's communication style may influence a supervisee's awareness of the supervisor's characteristics/backgrounds (Lee, 2017). Taken together, these studies indicate that the ability of supervisors to demonstrate multicultural competence during supervision plays an important role in supervisees' professional growth.

The cross cultural supervisory relationship is enhanced when supervisors reflect upon themselves as cultural beings and consider their multicultural knowledge and skills (Soheilian et al., 2014). Soheilian and colleagues emphasized that supervisors should facilitate supervisees not only to explore their values, but also initiate the discussion of culture within the supervisory relationship. However, sharing cultural differences in cross-cultural supervision settings can be challenging for minority supervisees (Berkel et al., 2007). Given supervisees' minority positions and lower power within the relationship, many are reluctant to initiate a discussion of cultural differences during supervision (Ponterotto et al., 2010). Specifically, Western supervisors who use Western European models in supervision settings may experience conflict with culturally diverse supervisees' expectations (Sue & Sue, 2008). As a result, minority supervisees may be passive toward their supervisors. Regarding racial and ethnic issues in supervision, African American supervisees had fewer expectations on the supervisory relationship (Helms & Cook, 1999), while Asian supervisees may expect supervisors to offer direct advices to them (Lau & Ng, 2012). These varied expectations of the supervisory process need open and clear communication to positively influence a healthy and constructive supervisory relationship. Despite these communication challenges, Wong et al. (2013) assert that this exchange helps minority supervisees feel their cultures are appreciated and therefore can directly impact the minority supervisees' development.

**Responses to the Ethical Dilemmas**

The intention of the authors was to present everyday scenarios SCs may encounter when providing counseling

services to diverse students and their parents. Furthermore, the authors understand that there is no right answer to any given situation, thereby making it a dilemma. The responses provided for each of the dilemmas incorporates some of the strategies presented in this article and highlights the use of the ASCA Ethical Standards (ASCA, 2016) as a guide to provide culturally competent ethically services.

**Ethnic and Racial Identity**

1. Mrs. Camp decided on a realistic career goal for Damian based solely on her interpretation of his demographics before meeting with the student and providing him with an opportunity to express his career aspirations. Mrs. Camp, possibly unaware of her biases toward Damien, would benefit from supervision in the area of multicultural development. Additionally, this PSC violated several ASCA (2016) ethical standards, beginning with the Preamble, as well as Sections A.1. Supporting Student Development (A.1.a., A.1.e.) and A.4. Academic, Career, and Social/Emotional Plans (A.4.b.).

2. Mrs. Brown appears to have good intentions in her desire to provide Angelica with information regarding the need for Spanish-speaking persons in the workplace. Nonetheless, her assumptions regarding Angelica's race/ethnicity led her to believe that she spoke Spanish. This PSC could benefit from professional development and supervision to address her preconceived notions regarding her Latino students. Several ASCA (2016) ethical standards can assist Mrs. Brown in providing culturally responsive services to Angelica. Standards relevant to this scenario include the Preamble and Section B.3. Responsibility to Self (B.3.i.).

**Gender Identity and Expression**

3. Mrs. Windham places great importance on keeping students' confidentiality, as she knows this is the cornerstone of the profession. Additionally, she empathizes with Latisha's current desire to remain at her current school with her support system. Nonetheless, she also has a responsibility to report this student's living condition to the homeless liaison, and possibly the child protective agency. In addressing this dilemma, the following ASCA (2016) ethical standards can assist her: (a) Preamble and (b) Section A. Responsibility to Students (A.2.e., A.2.g., and A.6.c). While this counselor's intentions are admirable, the McKinney-Vento Homeless Education Assistance Improvements Act of 2001 (U.S. Department of Education, 2019) legally mandates the reporting of homeless youth, and this law supersedes both loyalty to

the student's wishes and ethical standards.

4. The professional school counselor desires to support the teacher and the student and views this situation as a problem with the system. This PSC has several ASCA (2016) ethical standards to support his decision to approach the principal judiciously. Guiding his decision are the following standards: (a) Preamble, (b) Section A. Responsibility to Students (A.10.a. and A.10.e.), (c) Section B. Responsibilities to the School (B.2.d., B.2.f., and B.2.g.). Finally, as a reminder to the principal, Mr. Byron could highlight the fact that, if the school was providing graduation cords to other clubs, it would legally have to provide them to the GSA as well.

**Disability**

5. Although the school provides support for their students receiving special services, the SC fails to consider the Preamble in the ASCA Ethical Standards (ASCA, 2016), which states that all students have equal access to a CSCP. Considering that Mrs. Rosario routinely delivers classroom lessons to the tenth-grade homerooms, she could collect additional data from the teacher and plan a unit to address the needs of all the students in the classroom, including the students with disabilities. A specific ASCA ethical standard pertaining to this scenario is Section A. Responsibilities to Students (A.10.g.). Depending on the results of the data, she could deliver lessons on topics such as academic self-confidence, study skills, and organizational skills.

6. The SC is in his first year of the profession, and providing services to students receiving Section 504 accommodations was not covered in his preservice program. Therefore, he experienced feelings of nervousness during the parent consultation. Reviewing the ASCA Ethical Standards (2016) will be helpful to this SC. Of course, Mr. Henderson would be wise to seek professional development and supervision on providing services to students with disabilities (Responsibilities to the School B.2.i.). In the meantime, the Preamble (ASCA, 2016) states that all students have equal access to a CSCP. Therefore, Mr. Henderson, after consultation with the teacher, and as part of the CSCP, can initially provide individual counseling to the student to establish a relationship and identify the strengths and challenges she is currently facing (A.1.c Supporting Student Development & A.10.g. Underserved and At-Risk Populations). A next step could be to include her in small group counseling with her peers (A.7. Group Work) to help her

develop her sense of belonging in the classroom.

**Economic Status**

7. Yusef's family, much like many other families living in poverty, faces many barriers, including financial resources. The lack of free tutoring at school for Yusef sounds like a systemic problem that is undoubtedly affecting other students from lower economic status households. This PSC could use their advocacy efforts to address this barrier. Specific ASCA (2016) ethical standards appropriate for this situation include (a) Preamble, (b) Section A. Responsibilities to Students (A. 3. 8.), and (c) Section B.3 Responsibilities to Self (B.3.i.).

8. The low attendance at this valuable workshop provides evidence that families living in poverty face many barriers. This PSC had a legitimate concern for her own children that warrants respecting. Possibly, adhering to the following ASCA (2016) ethical standards (a) Preamble, (b) Section A.1. Supporting Student Development (A.1.d.), (c) Section A.10. Underserved and At-Risk Populations (A.10.d.), and (d) Section B.1. Responsibilities to Parents/Guardians (B.1.h.) could assist this PSC in brainstorming ways to ameliorate the barriers her parents faced in attending the workshop. Some suggested strategies include asking someone else to present the workshop, providing childcare, and/or scheduling multiple workshops to be held on different days (e.g., Saturday morning) or in an easily assessable community location (e.g., apartment clubhouse).

## References

American Association of Suicidology (2019, May). U.S.A. suicide: 2017 official final data. https://suicidology.org/wp-content/uploads/2019/04/2017datapgsv1-FINAL.pdf.

American Counseling Association (2014). 2014 ACA code of ethics. https://www.counseling.org/knowledge-center

American School Counselor Association (ASCA-2016). *ASCA ethical standards for school counselors*. ASCA. https://www.schoolcounselor.org/asca/media/asca/Ethics/EthicalStandards2016.pdf

American School Counselor Association (ASCA-2019). ASCA school counselor preparation program standards. https://www.schoolcounselor.org/asca/media/asca/Standards/ASCA-Standards-for-School-Counselor-Preparation-Programs.pdf

American School Counselor Association (ASCA-2019). *The ASCA national model: A framework for school counseling programs* (4th ed.). ASCA.

American College Testing (ACT-2015, October). *The condition of college and career readiness 2015: Students from low-income families*. https://equityinlearning.act.org/wp-content/uploads/2016/06/2015-low-income.pdf

Au, K. H. (2013). Helping high schools meet higher standards. *Journal of Adolescent & Adult Literacy, 56*, 535–539. doi: 10.1002/JAAL.179

Ball, A., Dawn, A-B, Mellin, E. A., & Green, J. H. (2010). A cross-walk of professional competencies involved in expanded school mental health: An exploratory study. *School Mental Health, 2*, 114–124. doi: 10.1007/s12310-010-9039-0

Buckley, M., & Mahdavi, J. N. (2018). Bringing children from the margins to the page: School counselors supporting students with learning disabilities. *Journal of School Counseling, 16*(23). http://www.jsc.montana.edu/articles/v16n23.pdf.

Chao, R. C-L. (2013). Race/ethnicity and multicultural competence among school counselors: Multicultural training, racial/ethnic identity, and color-blind racial attitudes. *Journal of Counseling and Development, 91*, 140–151. doi/abs/10.1002/j.1556-6676.2013.00082.x

Council for Accreditation of Counseling & Related Education Programs (2016). 2016 CACREP standards. Author.

Data USA (2019, October). Counselors. https://datausa.io/profile/soc/211010/

Davis, K. M., Lambie, G. W., & Ieva, K. P. (2011). Influence of familial spirituality: Implications for school counseling professionals. *Counseling and Values, 55*, 199–209.

Dunnell, C. (2018). Work in progress: Schools have come a long way in supporting LGBTQ students and faculty, but they must continue to examine how that mission aligns with actions. *Independent School,* 78, 84-88.

Foss, L. L., Generali, M. M., & Kress, V. E. (2011). Counseling people living in poverty: The CARE model. *Journal of Humanistic Counseling, 50*, 161–171. doi: 10.1111/j.1752-0606.2000.tb00290.x

Gallo, L. L. (2014). Spirituality and school counselor education and supervision. *Journal of School Counseling, 12*(6), 1–21. Retrieved from http://www.jsc.montana.edu/articles/v12n6.pdf

Goodman-Scott, E. & Boulden, R. (2020). School counselors' experience with the Section 504 process: "I want to be a strong member… [not] a case manager. *Professional School Counseling, 29(1*), 1-9.

Groce, L.L. E. (2012). *The use of words by school counselors: Exploring the hope for college enrollment of students of color.* (Doctoral dissertation). https://getd.libs.uga.edu/pdfs/groce_lavonna_l_201205_phd.pdf.

Grothaus, T. (2018). School counselors serving students with disruptive behavior disorders. *Professional School Counseling, 4*, 245-255. doi.org/10.1177/2156759X12016002S04

Human Rights Campaign (2018). 2018 youth report. Retrieved from https://www.hrc.org/resources/2018-lgbtq-youth-report doi:10.4135/9781483371283.n206

Individuals with Disabilities ACT (IDEA, n.d.). About IDEA. https://sites.ed.gov/idea/about-idea/

Johnson, G. S. (2017). School counselors supporting the career and college preparedness of students from poverty: Using the CARE model. *Journal of School Counseling, 15*(18), 1–27. http://www.jsc.montana.edu/articles/v15n18.pdf

Kann, L., Olsen, E.O., McManus, T., William, A.H., Shanklin, S.L., Flint K.H., Queen, B., Lowry, R., Chyen, D., Whittle, L., Thornton, J., Lim, C., Yamakawa, Y., Brener, N., & Zaza, S. (2016). Sexual identity, sex of sexual contacts, and health–related behaviors among students in grades 9-12–United States and selected sites. MMWR. *Surveillance Summaries 65*(9), 1-202. doi: 10.15585/mmwr.ss6509a1

Lambie, G. W., Davis, K. M., & Miller, G. (2008). Spirituality: Implications for professional school counselors' ethical practice. *Counseling and Values, 52*, 211–223.

McDowell, Goessling, & Melendez. (2012). Transformative learning through international immersion: Building multicultural competence in family therapy and counseling. *Journal of Marital and Family Therapy, 33*(2), 365-279. doi: 10.1111/j.1752-0606.2010.00209.x

Merriam–Webster Dictionary (2019). Race. https://www.merriam-webster.com/dictionary/race

Moss, L. G., & Singh, A. A. (2015). White school counselors becoming racial justice allies to students of color: A call to the field of school counseling. *Journal of School Counseling, 13*(5), 1–36.

National Center for Education Statistics (2020a, October). Children and youth with disabilities. https://nces.ed.gov/programs/coe/indicator_cgg.asp

National Center for Education Statistics (2020b, October). Students with disabilities. https://nces.ed.gov/fastfacts/display.asp?id=64

National Center for Children in Poverty (2019, October). Child poverty. http://www.nccp.org/topics/childpoverty.html

Newell, E. (2013). Building a culture of college and career readiness. *Techniques: Connecting Education & Careers, 88*(4), 42–46.

Nichter, M. & Edmondson, S. L. (2005). Counseling services for special education students. *Journal of Professional Counseling: Practice, Theory, & Research, 33,* 50-62.

Odgers, C. L. (2015). Income inequality and the developing child: Is it all relative? *American Psychologist, 70*(8)*,* 722–731. doi: doi.org/10.1037/a0039836

Parikh, S. B., Post, P., & Flowers, C. (2011). Relationship between a belief in a just world and social justice advocacy attitudes in school counseling. *Counseling and Values, 56*, 57–72. doi: 10.1002/j.2161-007X.2011.tb01031.x.

Payne, E., & Smith, M. (2018). Refusing relevance: School administrator resistance to offering professional development addressing LGBTQ issues in schools. *Educational Administration Quarterly,* 2, 183-215.

Romano, D.R., Paradise, L.V., & Green, E.J. (2009). School counselors' attitudes towards providing services to students receiving Section 504 classroom accommodations: Implications for school counselor educators. *Journal of School Counseling, 7*(37). http://www.jsc.montana.edu/articles/v7n37.pdf

Schnenck, P. M., Anctil, T. M., Smith, C. K., & Dahir, C. (2010). Coming full circle: Reoccurring career development trends in schools. *The Career Development Quarterly, 60*, 221–230. doi: 10.1002/j.2161-0045.2012.00018.x

Sklare, G. B. (2005). *Brief counseling that works: A solution-focused approach for school counselors and administrators* (2nd ed.) Corwin Press.

Sink, C., & Devlin, J.M. (2011). Student spirituality and school counseling: Issues, opportunities, and challenges. *Counseling and Values, 55*, 130-148.

doi: 10.1002/j.2161-007X.2011.tb00027.x

Sink, C. (2004). Spirituality and comprehensive school counseling programs. *Professional School Counseling, 7*, 309–315.

Stone, C. (2017). *School counseling principles: Ethics and law (4th ed.)*. American School Counseling Association.

The Advocacy Institute (2015). Analysis finds students with disabilities served under Section 504 overwhelmingly White, disproportionally male. https://www.advocacyinstitute.org/resources/504analysisCRDC2012.shtml

U.S. Census Bureau (2014). A more diverse nation. https://www.census.gov/content/dam/CensusCensus/newsroom/releases/2015/cb15-113_graphic.pdf

U.S. Census Bureau (2016). Hispanic student population on the rise. https://www.census.gov/content/dam/Census/library/visualizations/2017/comm/hispanic-school.jpg

U.S. Department of Education (2019, October). Part C - Homeless Education. https://www2.ed.gov/policy/elsec/leg/esea02/pg116.html

Walsh, C., & Townsin, L. (2018). A border-crossing pedagogy to disrupt LGBTIQ+ bullying and violence in schools. *English in Australia*, *53,* 18-27.

West-Olatunji, C., Goodman, R. D., & Shure, L. (2011). Use of multicultural supervision with school counselors to enhance cultural competence. *Journal of School Counseling, 9*(16), 1–29. http://www.jsc.montana.edu/articles/v9n16.pdf

Williams, J., Steen, S., Albert, T., Dely, B., Jacobs, B., Nagel, C., & Irick, A. (2015). Academically resilient, low-income students' perspectives of how school counselors can meet their academic needs. *Professional School Counseling, 19*, 155–165. doi:10.5330/1096-2409-19.1.155

Yoshikawa, H., Aber, J. L., & Beardslee, W. R. (2012). The effects of poverty on the mental, emotional, and behavioral health of children and youth: Implications for prevention. *American Psychologist, 67*, 272-284. doi: 10.1037/a0028015

# *Counselor, Know Thyself. The Impact of Mental Health Literacy and Stigma on Stress and Satisfaction in Practicing Counselors.*

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**Allison Crowe**
*East Carolina University*
**Patrick Mullen**
*William & Mary*
**Allison Spargo**
*Walden University*

**Abstract**
As a professional counselor, awareness of one's attitudes, biases, and assumptions is critical. Previous research has demonstrated that counselors are not immune to stigma nor to negative attitudes towards mental illness and seeking professional services when concerns arise. Furthermore, researchers have begun to explore relationships between mental health literacy and stigma and how these impact stress and satisfaction levels. To examine these variables in practicing counselors, the current study surveyed a total of 145 participants. Findings from this research indicated that higher levels of self-stigma and negative attitudes towards help-seeking predicted greater levels of stress and less life satisfaction. Mental health literacy did not predict stress or life satisfaction. These results are discussed with emphasis on clinical implications.

Mental illness impacts a large portion of the overall population in the United States, with nearly one in five U.S. adults diagnosed (44.7 million in 2016; National Institute of Mental Health, 2019). Despite its prevalence, a treatment gap exists between those who struggle with mental illness and those who seek formal psychological services to treat it. In fact, in a given year, approximately 60% of adults with a mental illness will not receive services (Substance Abuse and Mental Health Services Administration, 2015). Many posit that a portion of this treatment gap, the difference between those who need and those who seek services, stems from stigma (Crowe et al, 2018; Demyttenaere et al., 2004; Shidhaye & Kermode, 2013). Stigma has been said to include a variety of combined factors. Self-stigma (Vogel et al., 2006) describes the stigma that a person internalizes while public stigma includes attitudes and beliefs from mainstream society that shape the way people view

Correspondence concerning this article should be addressed to Allison Crowe, 225 Ragsdale Hall, Mailstop 121, Department of Interdisciplinary Professions, East Carolina University, Greenville, NC 27858. Email: crowea@ecu.edu

mental illness. Stigma towards help-seeking reflect how one views getting formal support, such as counseling or medication management (Mojtabai et al., 2016).

Mental health literacy, or knowledge about mental illness, may also impact attitudes towards mental illness. A lack of understanding of mental health (e.g., only "crazy" people go to a counselor) plays a role in biases and assumptions (Crowe et al, 2018; Lyndon et al, 2019; Jorm, 2000). Recent research has sought to uncover the intersection of mental health literacy, stigma, and help-seeking (Cheng et al., 2018) and has found that mental health literacy predicted help-seeking attitudes beyond self-stigma.

In the counseling and related mental health literature, a call has been made for professionals to look inward and explore stigmas they themselves may hold (Mullen & Crowe, 2017). Working in the mental health profession does not exclude one from struggling with, and needing professional services for, mental illness. In fact, counselor training programs frequently recommend that counselors in training (CITs) "know thyself" and take advantage of counseling services in order to increase self-awareness before practicing clinically. Moreover, studies have suggested that mental health professionals do indeed hold stigmatizing attitudes towards seeking formal psychological help, suggesting that there is more work to be done to normalize help-seeking for mental health concerns, even with mental health professionals (Mullen & Crowe, 2017). Among practicing counselors, stress and satisfaction have been studied as they relate to stigma and help-seeking (Mullen & Crowe, 2017; Lyndon et al, 2019). Drawing on the previous findings that life satisfaction and stress are negatively correlated (Buser & Kearney, 2017) and that stress and satisfaction are related to stigma and attitudes towards help-seeking (Mullen & Crowe, 2017), the current study explored stigma, stress, satisfaction, and mental health literacy among practicing professional counselors. Like Chen et al. (2018), we used Cauce et al.'s (2002) Model for Mental Health Help Seeking as a starting point, extending this to mental health professionals and integrating previous work related to stress and satisfaction.

## Review of the Literature

### Stigma and Attitudes Toward Treatment

Unfortunately, many individuals do not seek support for mental health concerns due to the fear of judgment, discrimination, and stereotyping from others. Public stigma, or the stigma that exists in the general population about individuals with mental health concerns (Corrigan & Watson, 2002; Parcesepe & Cabassa, 2012; Pescosolido, 2013), perpetuates fears about being perceived as dangerous. These stereotypes are common, when in fact those with mental illness are no more dangerous than those without (Rössler, 2016). Other common myths about mental illness relate to being unpredictable or are somehow to blame (i.e., they could have done something to prevent the illness, or did something to bring it on themselves). Additionally, stereotypes that

those with mental illness abuse the healthcare system have longstanding and widespread consequences in the lives of those diagnosed (Rössler, 2016). Self-stigma, or stigma that becomes internalized (Corrigan, 2004), has been named as one of the most serious effects of public stigma. When public stigma becomes internalized, the person experiences shame, self-loathing, and other negative emotions that can then develop into a cyclical pattern. Some posit that the stigma and perceptions about having a mental health concern are more harmful than the illness itself (Feldman & Crandall, 2007).

The relationship between stigma and help-seeking is clear, with stigma negatively impacting one's willingness to seek help (Crowe et al., 2016). One study indicated that attitudes toward mental health treatment could be predicted by the familiarity of mental health, level of stress, self-stigma, and public stigma of mental illness. Additionally, study results indicated that familiarity with mental health services is a strong indicator of one's attitudes toward mental health treatment. Life satisfaction, which was related to stress, self-stigma, and public stigma of mental illness, was not found to predict attitudes toward mental health treatment. The sample included adults from the general population, so while this study shed light on how these concepts are related, it was not specific to those in the mental health profession (Lyndon et al., 2019). Thus, further exploration of these concepts among counselors is warranted.

**Mental Health Literacy and Stigma**

Mental health providers and others, ranging from school counselors, psychiatrists, and nurses, have expressed negative attitudes about seeking help themselves and towards the clients they serve, suggesting that stigma extends to mental health professionals (Corrigan, Druss, & Perlick, 2014; Mullen & Crowe, 2017, 2010). Mental health literacy, or the knowledge that one holds about what a mental illness and how to treat it, has been examined as it relates to stigma. A number of researchers (Crowe et al., 2018; Chen et al., 2018; Evans-Lacko et al., 2010; Jorm, 2000; Kutcher et al., 2016) have studied mental health literacy hoping to improve public knowledge about mental health, decrease related stigma, and promote help-seeking behaviors. However, this body of research is small, and an exploration of the benefits of increased mental health literacy has only just begun in the field of counseling (Evans-Lacko et al., 2010; Jorm, 2000; Kutcher et al., 2016). A recent study explored mental health literacy, self-stigma, and health outcomes in a sample of patients from the general population. Results suggested that there is a significant relationship between self-stigma of mental illness and mental health literacy and a large negative statistically significant relationship between self-stigma of help-seeking and mental health literacy (Mullen & Crowe, 2017).

Chen and colleagues (2018) investigated self-stigma and mental health literacy as predictors of college students'

help-seeking attitudes, with an additional focus on demographic variables such as gender and race/ethnicity. They found that above and beyond self-stigma, mental health literacy predicted attitudes about seeking psychological help. Asian-American race/ethnicity, gender (male), familiarity with or prior experience with seeking help, and psychological distress also were significant predictors of help-seeking attitudes among the sample. These studies (Mullen & Crowe, 2017; Chen et al., 2018) exploring mental health literacy and attitudes towards mental health and help-seeking provide useful findings and a conceptual foundation upon which the current study was built. The current research extended this line of inquiry by sampling practicing counselors. We must uncover potential stigma within professional counselors, as these may negatively impact the therapeutic relationship.

**Stress, Satisfaction, and Stigma**

While stress is not a diagnosable concern, it can lead to more significant mental health issues when left untreated (Jason et al., 2003). It could be that when one experiences significant stress, one feels *more inclined* to seek assistance for a mental health concern. Or the opposite may be true for those experiencing a high level of stress in that stress may *inhibit* the individual from seeking treatment. Similarly, satisfaction with life may be inversely related to seeking treatment for a mental health concern. For example, if someone feels satisfied with their current life circumstances, he or she may be more likely to search for support when satisfaction levels are lower. In a study involving school counseling professionals, those who reported higher self-stigma also reported less help-seeking behaviors. This lack of help-seeking then contributed to higher levels of stress and burnout and lower satisfaction in the sample. Based on findings from previous research, literature supports that stigma, stress, and burnout are intertwined and that there is more to glean from a study exploring these variables within professional counselors (Mullen & Crowe, 2017). As stress and burnout are known to be present in the lives of professional counselors (Lent, 2010; Lent & Schwartz, 2012) and stigma has been found to deter help-seeking when significant stress is experienced (Mullen & Crowe, 2017; Hubbard et al., 2018), research that continues this line of inquiry can shed light on more relationships for practicing counselors.

**Current Study**

The current study examined the relationship of self-stigma, attitudes towards help-seeking, and mental health literacy on stress and life satisfaction among practicing counselors. Specifically, the following research questions guided this investigation:

*Research Question One*: Do mental health literacy, self-stigma of mental illness, and attitudes towards professional help-seeking predict practicing counselors' perceived stress?

*Research Question Two*: Do mental health literacy, self-stigma of mental illness, and attitudes towards professional help-

seeking predict practicing counselors' life satisfaction?

The Model for Mental Health Help Seeking (Cauce et al., 2002) that we used to frame our understanding of some of the study concepts describes three aspects of help-seeking: (a) recognizing the mental health problem, (b) deciding to seek help, and (c) selecting a service. One's world view, shaped by demographics such as gender, race, and ethnicity, influences these three domains of the model. Mental health literacy, self-stigma, and help-seeking were all thought to impact stress and satisfaction in practicing counselors.

## Methods

### Participants

The mean age of participants was 43.55 (*SD* = 10.9) and the majority of participants identified themselves as female (*n* = 133, 91.7%; male, *n* = 11, 7.6%; other, *n* = 1, .7%). Participants reported an average of 8.66 (*SD* = 7.02) years of experience as a counselor. Most participants identified as White (non-Hispanic; *n* = 84, 57.9%) followed by Black or African-American (*n* = 26, 17.9%), Hispanic (*n* = 24; 16.6%), Multiracial (*n* = 5, 3.4%), and Asian-American (*n* = 3, 2.1%), along with three participants reporting Other (2.1%). Participants worked in various settings, including Mental Health Agencies (*n* = 41, 28.3%), Private Practice (*n* = 39, 26.9%), School Settings (*n* = 26, 19.9%), Substance Abuse Settings (*n* = 23, 15.9%), College Counseling (*n* = 8, 5.5%), and Crisis Centers (*n* = 8, 5.5%).

### Procedures

Institutional Review Board approval was granted prior to beginning the study. This correlational research investigation employed survey data to explore the relationship between counselors' life satisfaction, stress levels, help-seeking attitudes, self-stigma, and mental health literacy. Practicing counselors were surveyed using Qualtrics. Invitation emails were sent to participants using an alumni database from a single, large, southeast university and southeastern state licensure database. These databases were chosen to capture participants who had completed the educational requirements for professional counseling and were assumed to be practicing professionals. The response rate from these databases was not collected due to a large number of undeliverable returned emails and responses that did not meet inclusion criteria. Interested participants were able to continue to the survey through a secure link. The emails and survey procedures met the recommendations set by the Tailored Design Method. Two follow up emails were sent at five-week intervals as described by the tailored design procedure (Dillman et al., 2009). The working sample for this research was 145 participants. An a-priori power analysis using the G*Power program (Version 3.1.9.2) indicated a minimum sample size of 133 for a linear multiple regression analysis with 90% power, an alpha of .001, and an anticipated medium effect size with three predictor

variables. Therefore, this sample size was suitable for our study.

## Measures

Instruments used in this study included the Perceived Stress Scale (PSS; Cohen et al., 1983), the Satisfaction with Life Scale (SLS; Diener et al., 1985), the Self-Stigma of Mental Illness Scale (SSOMI; Tucker et al., 2013), the Attitudes Toward Mental Health Treatment (ATMHT; Brown et al., 2010), and the Mental Health Knowledge Schedule (MAKS; Evans-Lacko et al., 2010). In addition to these formal measures, a demographic form was created to gather data on respondents' characteristics (e.g., gender, age, and ethnicity) and their experience with mental health treatment, including type of treatment, how much treatment they had received, and whether this experience had been positive or negative. The following section describes the instruments used in this study.

### *PSS*

The PSS (Cohen et al., 1983) was used to examine participants' level of stress. The PSS is a 10-item, one-dimensional self-report measure that assesses an individual's degree of perceived stress. Participants rated the frequency for which they had experienced stress over the previous 30 days on a scale from 0 (*never*) to 4 (*very often*). Sample items included "In the last month, how often have you felt that things were going your way" (reverse coded), In the last month, how often have you been able to control irritations in your life?" and "In the last month, how often have you felt nervous and 'stressed'?" Total scores were calculated by reversing items 4, 5, 7, and 8 and summing the items. Participants' average scores were found by dividing the total score by 10. Higher scores on the PSS indicated a higher degree of stress in participants' lives. The reliability of participants' scores on the PSS has been shown to be good in prior research, with Cronbach's alpha values ranging from .84 to .91 (Chao, 2011; Cohen et al., 1983; Daire et al., 2014). The Cronbach's alpha of the PSS scores for this investigation was .87, which indicated good internal consistency reliability.

### *SLS*

The SLS (Diener et al., 1985) was used to measure individuals' satisfaction with life. The SLS is a 5-item, one-dimensional self-report measure in which participants are asked to indicate their level of agreement with items on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*). Sample items include "I am satisfied with life," "The conditions of my life are excellent," and "If I could live my life over, I would change almost nothing." Total scores were calculated by summing each item. Average scores were obtained by summing each item and dividing total scores by the total number of items. Higher scores suggest greater general satisfaction with life. The reliability of participants' scores on the SLS has been good in prior research with a Cronbach's alpha value of .83 (Vera et al., 2011; Wei et al., 2012). The Cronbach's

alpha of the SLS scores for this investigation was .87, providing evidence of good internal consistency reliability.

### *SSOMI*

The SSOMI (Tucker et al., 2013) was used to assess self-stigma of mental illness. The SSOMI is a 10-item, one-dimensional self-report measure that assesses a person's internalized stigma related to having a mental illness. Respondents rated their level of agreement to 10 statements regarding mental illness on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Some sample items included "I would feel inadequate if I had a mental illness," "I would feel okay about myself if I had a mental illness" (reverse coded), and "If I had a mental illness, I would be less satisfied with myself." Total scores were calculated by reversing items 2, 5, 7, and 9 and then summing the items. Participants' average scores were calculated by dividing the total score by the total number of items. Higher scores on the SSOMI indicated greater self-stigma towards mental illness. The participants' scores on the SSOMI has been good in prior research with Cronbach's alpha values ranging from .86 to .92 (Tucker et al., 2013; Vogel et al., 2006). Recent use of the SSOMI suggests the scale's strong reliability ($\alpha = .93$, Mullen & Crowe, 2017). For this study, Cronbach's alpha value was .90, which indicated strong internal consistency reliability.

### *ATMHT*

The ATMHT (Brown et al., 2010) is a 20-item, 4-point Likert-type scale and reflects an individual's attitude towards professional mental health treatment. The ATMHT is a modified version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fisher & Turner, 1970). The ATSPPHS scale is comprised of 29 items and includes outdated language. Brown et al. (2010) noted that it also neglects to factor in culture, so these researchers modified the original scale by including language that was more inclusive and easier to understand in the 20-item ATMHT scale. Sample items include "I feel confident that I could find a therapist who is understanding and respectful of my ethnicity/culture" and "In my community, people take care of their emotional problems on their own; they don't seek professional mental health services." Higher scores indicate more positive attitudes about seeking mental health treatment. Brown et al. (2010) found that the internal consistency scores for the total sample were adequate (.75). They also looked at subgroups according to ethnicity and found that the scale had a Cronbach's alpha of .78 for White participants and .73 for African-American participants. In this study, the Cronbach's alpha value was .82, which indicated strong internal consistency reliability.

### *MAKS*

The MAKS (Evans-Lacko et al., 2010) is an instrument designed to assess

stigma-related mental health literacy among the general public. The scale includes 12 items scored on a Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). A total score is calculated by adding the item values together. Items 6, 8, and 12 are reverse scored. Items 7 and 12 are designed to establish levels of recognition and familiarity with a variety of mental health conditions and conceptualize responses to the other scale items. In other words, researchers can assess whether a broadened conceptualization of mental illness impacts one's successive responses to questions. Sample items include "If a friend had a mental health problem, I know what advice to give them to get professional help." A recognition item has the following instructions preceding it: "For the following items, say whether you think each condition is a type of mental illness by ticking one box only." Varying severities of mental illness as well as non-clinical issues are then listed, including "stress," "drug addiction," and "schizophrenia." In its initial development, Evans-Lacko and associates (2010) utilized an extensive review board of experts to support the content validity of the MAKS. Overall test-retest reliability was .71 using Lin's concordance statistic, and item retest reliability ranged from .57 to .87 (Evans-Lacko et al., 2010). Internal consistency has ranged from poor ($\alpha = .65$) to acceptable ($\alpha = .73$) in prior research (Evans-Lacko et al., 2010; Authors, 2018; respectively). In the current study, the Cronbach's alpha was .62, indicating questionable internal consistency reliability.

**Data Analyses**

Upon completion of the survey procedures, data were consolidated into SPSS (version 24) for management and analysis purposes. To address the research questions in this study, we performed Pearson's correlations and linear multiple regression analyses. In our initial screening, we identified no missing data and three cases with univariate or multivariate outlier variables using converted z-scores and Mahalanobis Distance probability. We performed the analyses with the original values and with winsorized version of the values and found no meaningful differences in the results. Therefore, we elected to include the original values in the analysis. Next, we examined the assumptions of linearity, homoscedasticity, and normality (Osborne & Waters, 2002). A visual inspection variable histograms, P-Plots, plots of the standardized residuals, and an examination of the variance inflation factor (range from 1.02 to 1.14) indicated the data met the statistical assumptions for the analyses in this study. For the linear multiple regression analyses, we also applied structure coefficients due to a degree of association among the predictor variables (Courville & Thompson, 2001).

## Results

**Research Question One**

Table 1 provides the correlations, means, and standard deviations for the variables in this study. A standard linear multiple regression was applied to the

dependent variable of perceived stress and the independent variables of mental health literacy, self-stigma of mental health illness, and attitudes towards professional help-seeking. Overall, the linear composite of predictor variables predicted 15% ($R^2$ = .15) of the variance in counselors' perceived stress, $F$ (3, 144) = 8.06, $p$ < .001. Standardized regression coefficients of the individual predictor variables indicated that high levels of self-stigma of mental illness ($\beta$ = .24, $p$ < .01) and attitudes towards professional help-seeking were significant ($\beta$ = -.24, $p$ < .01) in predicting perceived stress. However, mental health literacy was not a significant predictor ($\beta$ = .05, $p$ = .57). Structure coefficients also indicated that self-stigma of mental illness ($r_s$ = .81) and attitudes towards professional help-seeking ($r_s$ = -.80) were the best predictors of perceived stress, followed by mental health literacy ($r_s$ = .07).

### Research Question Two

A second standard linear multiple regression was applied to the dependent variable of life satisfaction and the independent variables mental health literacy, self-stigma of mental illness, and attitudes towards professional help-seeking. Overall, the linear composite of predictor variables predicted 13% ($R^2$ = .13) of the variance in counselors' life satisfaction, $F$ (3, 144) = 7.30, $p$ < .001. Standardized regression coefficients of the individual predictor variables indicated that high levels of attitudes towards professional help-seeking ($\beta$ = .25, $p$ < .01) and self-stigma of mental illness ($\beta$ = -.18, $p$ < .05) predicted life satisfaction. However, mental health literacy was not a significant predictor ($\beta$ = .08, $p$ = .33). Structure coefficients also indicated that attitudes towards professional help-seeking ($r_s$ = -.86) and self-stigma of mental illness ($r_s$ = -.71) were the best predictors of life satisfaction, followed by mental health literacy ($r_s$ = .27).

## Discussion

### Stress, Self-Stigma, Help-Seeking Attitudes, and Mental Health Literacy

It is important to identify potential reasons for counselor stress in order to reduce this stress, as well as and burnout (Mullen & Crowe, 2017). Results of this study indicate that higher levels of self-stigma and negative attitudes toward professional help-seeking significantly predict stress. In other words, when the counselor has higher self-stigma and more negative attitudes towards seeking professional help, their stress level is impacted. The awareness of the interaction between these variables is valuable information for counselors and counselor educators so that we can evaluate and monitor these internalized stigmas in students, trainees, and professional counselors. Although mental health knowledge is essential for professional counselors, results of this study indicate that mental health literacy is not a significant predictor of stress. Thus, knowledge about mental health does not seem to impact counselors' stress levels. These results indicate that we cannot merely increase knowledge as a stress-reduction technique,

or assume ones' knowledge about mental health on a professional level might result in less stress since literacy did not impact levels of stress in counselors. Instead, these findings suggest that we consider additional tools such as attending to attitudes and internal processes such as internalized stereotypes and personal assumptions in order to shift negative perceptions and stigmas and improve stress and satisfaction.

When compared to Chen et al.'s (2018) study, our results related to mental health literacy differed. In the current study, mental health literacy was *not* a significant predictor of stress or satisfaction in practicing counselors. Chen et al.'s study did not focus on stress and satisfaction as the current research did, but mental health literacy was a strong factor (above and beyond stigma) in help-seeking attitudes. This seems to suggest that mental health literacy might be a topic of future research as, in contrast to previous work (Chen et al., 2018), this study did not find it to be as significant a construct in the interplay of similar concepts. Perhaps mental health literacy impacts those in the counseling field differently than those who may be less knowledgeable about mental health. For instance, professional counselors may choose this career path with a specific interest in learning more about treatment of mental health. Because of the aspect of choice, rather than a personal experience such as dealing with family members with mental illness, professional counselors may expect to encounter stress and satisfaction and may have a different level of locus of control compared to the general population. Another noteworthy consideration related to counselors and mental health literacy is that, it can be assumed that practicing counselors who have specialized training in mental health possess more knowledge about mental health concerns, thus having more mental health literacy then the general population. Thus, the current sample was perhaps inherently different than previous samples (Crowe et al., 2018; Chen et al., 2018; Evans-Lacko et al., 2010; Jorm, 2000; Kutcher et al., 2016). More research may help to uncover these nuances in mental health literacy impacts.

**Satisfaction, Self-Stigma, Help-Seeking Attitudes, and Mental Health Literacy**

In addition to looking at perceived stress, this study explored the impact of mental health literacy, self-stigma, and attitudes towards professional help-seeking on reported satisfaction in practicing counselors. In general, the above variables predicted 13% of the variance in counselors' life satisfaction with data indicating that both high levels of self-stigma and attitudes towards professional help-seeking had a significant impact on perceived satisfaction. In contrast, mental health literacy was not a significant predictor of life satisfaction. This information is valuable, demonstrating that cognitive learning and information is less predictive of life satisfaction than attitudes and internalized belief systems about the need and usefulness of mental health services. Rather than teaching and learning from a single cognitive perspective, it is vital to address the counselor's world view and the importance of belief systems related

to mental health care. Personal attitudes, beliefs, and assumptions rather than knowledge might be worthy of a closer investigation among practicing counselors, as mental health literacy did not appear to impact stress and satisfaction.

Results of this current study are consistent with previous findings that perceived life satisfaction and stress are negatively correlated (Buser & Kearney, 2017). Researchers have suggested that creating an internal locus of control may decrease stress (Gray-Stanley et al., 2010). The current study suggests that adjusting one's perception of the need and use of mental health services may impact perceived stress and overall life satisfaction.

The Model for Mental Health Help Seeking (Cauce et al., 2002) helped frame some of our understanding of the current study's concepts (i.e., attitudes towards help-seeking, stigma, and mental health literacy). The three aspects of help-seeking in the model include (a) recognizing the mental health problem, (b) deciding to seek help, and (c) selecting a service. One's world view influences these three domains. Perhaps in our sample, the world view of practicing counselors, who may have more mental health literacy and ability to recognize when a mental health concern arises, was different from that of those in the general population. Because our study focused on stress and satisfaction among practicing counselors and how these were impacted by mental health literacy, help-seeking, and stigma, we used the model only as a beginning frame of reference, and encourage more work to be done on researching this model's efficacy with practicing counselors, or those in the general population.

**Implications for Professional Counselors**

Internalized and socialized stigma related to mental health have been well documented in counseling literature (Oexle et al., 2018). Despite systemic approaches for changing attitudes towards mental health (Corrigan & Calabrese, 2005), a negative stigma remains (Mullen & Crowe, 2017). Additionally, stigma towards mental health and negative attitudes towards help-seeking persist among mental health service providers (Mullen & Crowe, 2017; Smith & Cashwell, 2010). The current study demonstrates how attitudes and stigma impact overall stress and life satisfaction among counseling professionals. Results indicate that a more positive attitude and a reduced level of self-stigma are associated with less stress and greater satisfaction. Although not a direct predictor of satisfaction, mental health literacy is also essential as it leads to decreased stigma and better attitudes towards help-seeking (Smith & Cashwell, 2010). The current findings are consistent with previous studies that demonstrate stigma is related to burnout (Mullen & Crowe, 2017), and that those counselors with higher levels of satisfaction possess less stigmatizing and negative attitudes towards help-seeking.

The implications for this research are relevant for counselors, counselor educators, and supervisors. Self-stigma of mental

illness and attitudes towards help-seeking are important variables for clinicians because they impact the therapeutic relationship. For instance, a clinician may use negative attending to alter the course of therapy, or may deal with counter-transference issues. Clients may have internalized stigmas (Lucksted et al., 2011), but professionals may also have unrecognized negative attitudes towards help-seeking. As counselors, it is essential to recognize that biases exist and may be an unconscious variable in clinical relationships. It is also essential to safeguard clients from negative attitudes and stigma that may influence conceptualization and treatment of clinical issues. Additionally, by attending to self-stigma and attitudes towards help-seeking, counselors may experience a decrease in stress and increase in life satisfaction. In a field focusing on self-care, perhaps addressing stigma is a novel approach to reducing burnout and improving overall satisfaction.

Clinical supervisors are in a unique position to make use of the results of this study. Supervisors of graduate-level and postgraduate trainees can bring awareness to their supervisees about the impact of internalized stigma and attitudes towards seeking help for a mental health concern. If a supervisee is experiencing symptoms of stress, burnout, or doubt about their professional identity, a supervisor may draw from this study the importance of addressing personal attitudes and beliefs about mental illness. In creating more positive attitudes and a less stigmatized response to mental health services, supervisors can assist their supervisees in finding more life satisfaction and decreasing stress levels.

In addition to increasing professional knowledge, counselor educators can use results of this study to demonstrate to counselors in training the need for continual attention to therapeutic relationships, personal values, and beliefs. Counselor educators can benefit from the results of this study as well. Educators may adjust teaching and supervision strategies with the awareness that increasing knowledge does not have a direct impact on reducing stress or increasing life satisfaction. Instead, counselor wellness can be facilitated through exploring and adjusting personal attitudes related to mental health and associated stigmas. Counselor educators can generate classroom dialogue and create activities that address not only knowledge but also attitudes and skills related to self-awareness of self-stigma and attitudes towards help-seeking.

Although the findings from the current study indicate that mental health literacy is not a direct predictor of stress and satisfaction, professionals can glean that knowledge has an impact on attitudes related to mental health services. As the results of the current study demonstrate, attitudes and stigma are important variables that impact stress and satisfaction. Increasing awareness and knowledge of mental health issues may reduce stigma and negative attitudes, having an indirect effect on these protective variables.

A final implication for counselors, counselor educators, and supervisors is the need to address help-seeking behaviors among mental health professionals. Counselors at all levels should be encouraged to discuss their own need for professional support. Self-stigma and attitudes towards help-seeking can potentially prevent professionals from obtaining professional help. Intra-professional advocacy and continued social activism to reduce the stigma of mental illness are ways in which counselors can use the findings of this study to create both micro- and macro-level change.

## Limitations and Implications for Future Research

As with any research, the current study is not without limitations. We used two sampling methods to recruit participants – an alumni database from a southeastern university and a state database. There were a large number of undeliverable email addresses which reduced the researcher's ability to determine response rates. This sampling method was chosen to increase the overall sample size, but it is a noteworthy limitation. Additionally, sampling bias could be present, those who did complete the survey may be a unique sub-group of professional counselors. As with any self-report data, there always is a possibility of social desirability. Finally, The Mental Health Knowledge Schedule demonstrated weak reliability with a Cronbach's alpha of .62, indicating questionable internal consistency reliability. Future research may consider other measures to assess mental health literacy.

A growing body of research has explored the role of self-stigma among mental health professionals. Research has shown that environment (Dir et al., 2018), knowledge, and previous experience with mental health services all have a role in self-stigma (Golberstein et al., 2008). The current study adds to the literature by exploring the role of counselors' stigma and how this might impact stress and satisfaction. This population is different from previously surveyed groups in that the participants were practicing counselors, who likely have a greater knowledge base than trainees or newer counselors under supervision. This unique demographic variable may shift the influence of knowledge about both self-stigma and help-seeking attitudes.

Directions for future research may seek to examine cultural variables related to internalized stigma related to mental health, specifically the role of race-gender schemas by which women counselors of color may operate (Watson & Hunter, 2015). Additional research may also seek to explore further the results of this study and those of Golberstein et al. (2008) as they relate to the personal and familial experience of mental health services and the relationship with both stigma and attitudes of mental health. An additional direction for future research is to examine the attitudes and stigma of substance abuse treatment.

## References


Buser, J. K., & Kearney, A. (2017). Stress, adaptive coping, and life satisfaction. *Journal of College Counseling*, *20*(3), 224–236. doi:10.1002/jocc.12071

Brown, C., Conner, K. O., Copeland, V. C., Grote, N., Beach, S., Battista, D., & Reynolds, C. F. (2010). Depression stigma, race, and treatment seeking behavior and attitudes. *Journal of Community Psychology*, *38*(3), 350–368. doi:10.1002/jcop.20368

Cauce, A. M., Domenech-Rodriguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, *70*(1), 44–55. doi:10.1037/0022-006X.70.1.44

Chao, R. C. (2011). Managing stress and maintaining well-being: Social support, problem-focused coping, and avoidant coping. *Journal of Counseling and Development*, *89*(3), 338–348. doi:10.1002/j.1556-6678.2011.tb00098.x

Chen, H. L., Wang, C., McDermott, R., Kridel, M., & Rislin, J. (2018). Self-stigma, mental health literacy, and attitudes towards seeking psychological help. *Journal of Counseling and Development*, *96*(1), 64–74. doi:10.1002/jcad.12178

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, *24*(4), 385–396. doi:10.2307/2136404

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614–625. doi:10.1037/0003-066X.59.7.614

Corrigan, P. W., & Calabrese, J. D. (2005). Strategies for assessing and diminishing self stigma. In P. W. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (pp. 239–256). American Psychological Association. doi:10.1037/10887-011

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, *1*(1), 16–20. https://www.ncbi.nlm.nih.gov/pmc/articles /PMC1489832/

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37–70. doi:10.1177/1529100614531398

Courville, T., & Thompson, B. (2001). Use of structure coefficients in published

multiple regression articles: β is not enough. *Educational and Psychological Measurement*, *61*, 229–248. doi: 10.1177/0013164401612006

Crowe, A., Averett, P., & Glass, J.S. (2016). Mental illness stigma, psychological help seeking: What are the relationships? *Mental Health & Prevention, 4*, 63-68. doi:10.1016/j.mhp.2015.12.001

Crowe, A., Mullen, P.R., & Littlewood, K. (2018). Self-stigma, mental health literacy, and health outcomes in integrated care. *Journal of Counseling and Development, 96,* 267-277.

Daire, A. P., Dominguez, V. N., Carlson, R. G., & Case-Pease, J. (2014). Family adjustment measure: Scale construction and validation. *Measurement and Evaluation in Counseling and Development*, *47*(2), 91–101. doi:10.1177/0748175614522270

Demyttenaere K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P., . . . WHO World Mental Health Survey Consortium. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association*, *291*(21), 2581–2590. doi:10.1001/jama.291.21.2581

Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, *49*(1), 71–75. doi:10.1207/s15327752jpa4901_13

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2009). *Internet, mail, and mixed-mode surveys: The tailored design method*. Wiley & Sons.

Dir, A. L., Saldana, L., Chapman, J. E., & Aalsma, M. C. (2018). Burnout and mental health stigma among juvenile probation officers: The moderating effect of participatory atmosphere. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–8. doi:10.1007/s10488-018-0902-x

Evans-Lacko, S., Little, K., Melzer, H., Rose, D., Rhydderch, D., Henderson, C., & Thornicroft, G. (2010). Development and psychometric properties of the Mental Health Knowledge Schedule. *Canadian Journal of Psychiatry*, *55*(7), 440–448. doi:10.1177 /070674371005500707

Feldman, D. B., & Crandall, C. S. (2007). Dimensions of mental illness stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology*, *26*(2), 137–154. doi:10.1521/jscp.2007.26.2.137

Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional

help: Development and research utility of an attitudes scale. *Journal of Counseling and Clinical Psychology*, *35*(1), 79–90. doi:10.1037/h0029636

Golberstein, E., Eisenberg, D., & Gollust, S. E. (2008). Perceived stigma and mental health care seeking. *Psychiatric Services*, *59*(4), 392–399. doi:10.1176/ps.2008.59.4.392

Gray-Stanley, J. A., Muramatsu, N., Heller, T., Hughes, S., Johnson, T. P., & Ramirez-Valles, J.(2010). Work stress and depression among direct support professionals: The role of worksupport and locus of control. *Journal of Intellectual Disability Research*, *54*(8), 749–761.doi:10.1111/j.1365-2788.2010.01303.x

Hubbard, K., Reohr, P., Tolcher, L., & Downs, A. (2018). Stress, mental health symptoms, and help-seeking in college students. *Psi Chi Journal of Psychological Research, 23*(4), 293-305.

Jason, L. A., Fennell, P. A., & Taylor, R. R. (2003). *Handbook of chronic fatigue syndrome.* John Wiley & Sons.

Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*, *177*(5), 396–401. doi:10.1192/bjp.177.5.396

Kutcher, S., Wei, Y., Costa, S., Gusmao, Skokauskas, N., Sourander, A. (2016). Enhancing mental health literacy in young people. *European Child & Adolescent Psychiatry, 25* (6), 567-569.

Lent, J. (2010). Stressors and stress management of counselors: Findings from interviews of professional counselors. http://counselingoutfitters.com/vistas/vistas10/Article_73.pdf

Lent, J., & Schwartz, R. (2012). The impact of work setting, demographic characteristics, and personality factors related to burnout among professional counselors. *Journal of Mental Health Counseling*, *34*(4), 355-372.

Lucksted, A., Drapalski, A., Calmes, C., Forbes, C., DeForge, B., & Boyd, J. (2011). Ending self-stigma: Pilot evaluation of a new intervention to reduce internalized stigma among people with mental illnesses. *Psychiatric Rehabilitation Journal*, *35*(1), 51–54. doi:10.2975/35.1.2011.51.54

Lyndom, A.E., Crowe, A., Wuensch, K.L., McCammon, S.L., & Davis, K.B. (2019). College students' stigmatization of people with mental illness: Familiarity, implicit person theory, and attribution. *Journal of Mental Health, 28*(3), 255-259. doi: 10.1080/09638237.2016.1244722

Mojtabai, R., Evans-Lacko, S., Schomerus, G., & Thornicroft, G. (2016). Attitudes toward mental health help-seeking behavior and use of mental health treatments. *Psychiatric Services*, *67*(6), 650–657. doi:10.1176/appi.ps.201500164

Mullen, P. & Crowe, A. (2017). Self-stigma of mental illness and help seeking among school counselors. *Journal of Counseling and Development, 95,* 401-411. doi: 10.1002/jcad.12155

National Institute of Mental Health. (2019). Mental health by the numbers. In *Statistics.*https://www.nimh.nih.gov/health/statistics/index.shtml/

Oexle, N., Rüsch, N., Viering, S., Wyss, C., Seifritz, E., Xu, Z., & Kawohl, W. (2017). Self-stigma and suicidality: A longitudinal study. *European Archives of Psychiatry & Clinical Neuroscience*, *267*(4), 359–361. doi:10.1007/s00406-016-0698-1

Osborne, J. W., & Waters, E. (2002). Four assumptions of multiple regression that researchers should always test. *Practical Assessment, Research & Evaluation*, *8*(2). http://PAREonline.net/getvn.asp?v=8&n=2

Parcesepe, A. M., & Cabassa, L. J. (2012). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Service Research*, *40*(5), 384–399. doi:10.1007/s10488-012-0430-z

Pescosolido, B. A. (2013). The public stigma of mental illness: What do we think; what do we know; what can we prove? *Journal of Health & Social Behavior*, *54*(1), 1–21. doi: 10.1177/0022146512471197

Rössler W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO reports*, *17*(9), 1250–1253. https://doi.org/10.15252/embr.201643041

Shidhaye R., & Kermode, M. (2013). Stigma and discrimination as a barrier to mental health service utilization in India. *International Health*, *5*(1), 6–8. doi:10.1093/inthealth/ihs011

Smith, A. L., & Cashwell, C. S. (2010). Stigma and mental illness: Investigating attitudes of mental health and non mental health professionals and trainees. *Journal of Humanistic Counseling, Education, & Development*, *49*(2), 189–202. doi:10.1002/j.2161-1939.2010.tb00097.x

Substance Abuse and Mental Health Services Administration. (2015). *Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-50, HHS

Publication No. (SMA) 15-4927. http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

Tucker, J. R., Hammer, J. H., Vogel, D., Bitman, R., Wade, N. G., & Maier, E. (2013). Disentangling self-stigma: Are mental illness and help-seeking self-stigmas different? *Journal of Counseling Psychology*, *60*(4), 520–531. doi:10.1037/a0033555

Vera, E., Vacek, K., Coyle, L., Stinson, J., Mull, M., Doud, K., . . . & Keene, C. (2011). An examination of culturally relevant stressors, coping, ethnic identity, and subjective well-being in urban, ethnic minority adolescents. *Professional School Counseling*, *15*(2), 55–66. doi:10.5330/PSC.n.2011-15.55

Vogel, D. L., Wade, N., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*(3), 325–337. doi:10.1037 /0022-0167.53.3.325

Watson, N. N., & Hunter, C. D. (2015). Anxiety and depression among African American women: The costs of strength and negative attitudes toward psychological help seeking. *Cultural Diversity and Ethnic Minority Psychology*, *21*(4), 604–612. doi:10.1037 /cdp0000015

Wei, M., Ku, T. Y., Chen, H. J., Wade, N., Liao, K. Y. H., & Guo, G. J. (2012). Chinese Christians in America: Attachment to God, stress, and well-being. *Counseling and Values*, *57*(2), 162–180. doi:10.1002/j.2161-007X.2012.00015.x

Table 1

*Correlations, Means, and Standard Deviations for the Variables in This Study*

| Variable | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 1. MAKS | - | | | | |
| 2. ATMHT | .11 | - | | | |
| 3. SSOMI | .03 | -.32** | - | | |
| 4. PSS | .03 | -.31** | .31** | - | |
| 5. SLS | .10 | .32** | -.26* | -.64** | - |
| ***M*** | 25.34 | 63.05 | 24.73 | 14.35 | 25.78 |
| ***SD*** | 2.71 | 6.49 | 7.67 | 6.55 | 5.96 |

*Note*. $N = 145$, MAKS = Mental Health Knowledge Schedule, ATMHT = Attitudes Towards Mental Health Treatment, SSOMI = Self-Stigma of Mental Illness, PSS = Perceived Stress Scale, SLS = Satisfaction with Life Scale, * $p < .01$, ** $p < .001$

# *Development and Validation of the Optimal Supervision Environment Test (OSET)*

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**Ki Byung Chae**
*University of North Carolina at Pembroke*
**Charles R. McAdams III**
*College of William and Mary*

**Abstract**
The purpose of this study was to develop and validate the Optimal Supervision Environment Test (OSET), an instrument designed to assess the supervisor's ability to create an optimal supervision environment. Using confirmatory factor analysis (CFA), the initial validation of the OSET has yielded a three-factor model that identifies the following three environmental domains of supervision: the Emotional Environment, the Learning Environment, and the Power Environment. The total scale and each OSET subscale have strong internal consistency (.84 to .90). These results provide initial support for using OSET as a valid and reliable multidimensional supervision instrument.

Supervision is a critical element in the training and development of professional counselors (Bernard & Goodyear, 2019). The supervisory relationship often is the most formative relationship that new counselors experience as they develop professional identities (Riggs & Bretz, 2006). Furthermore, supervision consistently promotes counselors' growth and development so that they satisfy the standards of the profession and ensure therapeutic effectiveness (Bernard & Goodyear, 2019). Several studies showed the effectiveness of supervision in promoting the growth and well-being of the counselors and positive client outcomes (Cashwell & Dooley, 2001; DePue et al., 2020; Gibson et al., 2009)

Despite the potential benefits of supervision, the experience of supervision can also be negative and even damaging for supervisees. For example, Gray et al. (2001) interviewed 13 psychotherapy trainees to explore their experiences in "counterproductive" supervision events. The researchers defined a counterproductive event as "any experience that was hindering, unhelpful, or harmful in relation to the trainee's growth as a therapist" (Gary et al., 2001, p. 371). Participants all reported at least one counterproductive experience, including supervisors dismissing trainees' thoughts and feelings, lacking empathy, and inappropriately self-disclosing.

Correspondence concerning this article should be addressed to Ki Byung Chae, University of North Carolina at Pembroke, P.O. Box 1510, Pembroke, NC 28372. Email: kibyung.chae@uncp.edu

Most perceived counterproductive events were attributed to supervisors not attending to their trainees' thoughts and feelings. After those experiences, trainees reported changing their behaviors toward their supervisors, most commonly by repressing disclosure. Nelson and Friedlander (2001), who interviewed 13 master's and doctoral-level trainees, reported that "bad supervisors" were viewed by trainees as being "remote and uncommitted to establishing a strong training relationship" (p. 387). As a result of perceived inadequatesupervision, some of the trainees reported experiencing long-lasting self-doubt and extreme stress.

In an effort to enhance supervision, considerable research interest has focused on the importance of matching supervisees' developmental levels with appropriate supervisory conditions, typically referred to as the supervision environment (Bernard & Goodyear, 2019). When supervisors match supervisory interventions to their supervisees' current developmental level and then mismatch their interventions to their supervisees by relating from the next developmental level, this approach optimize the supervisory environment. Stoltenberg (1981) noted that the optimal supervision environment is one in which there is a mismatch in challenge of about one-half step beyond the supervisee's current level of functioning. This optimal mismatch extends the supervisees' thinking but does not overwhelm the supervisees' thinking with more information that they can handle. Borders (1998), applying the framework of ego development, suggested that for supervisees to transition to a higher level of ego development within the context of supervision, the supervisor must be functioning at least one ego developmental stage higher than their supervisees.

## The Optimal Supervision Environment

To maximize the effectiveness of supervision and prevent inadequate and even harmful supervision, supervisors must strive to establish an optimal supervision environment through an ongoing process of adjusting their supervisory interventions based on the varying needs of supervisees. Drawing from the current research, it appears that this adjustment process must optimally occur in relation to three primary environmental dimensions: (a) the emotional environment, (b) the learning environment, and (c) the power environment.

### The Emotional Environment (EE)

Studies have demonstrated a strong association between supervisors' and supervisees' emotional bonds and various supervision outcomes (DePue et al., 2020; Ellis, 2010; Ladany, 2004; White & Queener, 2003). Ladany et al. (1999) investigated the relationships between supervisory alliance, supervisee self-efficacy, and supervisees' satisfaction with supervision. A strong emotional bond was found to be predictive of supervisees' satisfaction with supervision. As the emotional bond between supervisor and supervisee increased in strength, supervisees perceived their supervisors' personal qualities and performance and their

behaviors in supervision more positively. Additionally, supervisees perceived a higher level of comfort in supervision.

According to Watkins (2010), the supervisor establishes the relationship as a container or holding environment (Winnicott, 1965) to create a safe space for the supervisee, wherein trust, consistency, and dependability permeate every facet of the supervisory relationship. Watkins suggested that when the supervisee experience anxiety, the supervisor should provide comfort; when the supervisee has doubts, the supervisor should provide reassurance; and when the supervisee lacks direction, the supervisor should provide guidance. In effect, the supervisor creates a secure emotional refuge within which a supervisee can feel safe enough to assume the risks associated with the new experience of counselor training.

White and Queener (2003) found that a supervisor's ability to create secure adult attachments and social provision (i.e., social network) was predictive of both supervisees' and supervisors' perceptions of the supervisory working alliance. The supervisor's abilities to form close attachments and to feel intimate in relationships were found to be more predictive of a strong supervisory alliance than if the same characteristics brought to the supervisory relationship by supervisees. This finding further demonstrates the importance of a relational bond between supervisor and supervisee in the creation of a supervision environment that is perceived as supportive and effective. It also highlights the critical role that the supervisor plays in facilitating an emotional bond and secure attachment with supervisees that appears to be critical to an effective supervision environment.

**The Learning Environment (LE)**

To provide adequate supervision, Borders (1989b) suggested that supervisors must consider their supervisees as "learners" and themselves as "educators" who create productive learning environments (p. 6). More specifically, she and several other researchers have concluded that competent supervisors can create a learning environment in which their knowledge and skills are appropriately imparted to supervisees according to each supervisee's level of cognitive complexity (Borders, 1989a; Borders & Fong, 1989; Borders, et al., 1986; Ladany et al., 2001; Lovell, 1999). A developmentally matched supervision environment ensures that supervisees can accurately comprehend their new learning experiences; such an environment has also shown to promote supervisee capacity to comprehend increasingly complex learning concepts (Granello, 2002, 2010). In a study of 63 counseling practicum and internship students, Borders et al. (1986) found that students at lower ego levels used more simplistic, concrete descriptors of their experiences. In contrast, those at higher ego development levels used more sophisticated and interactive descriptors. In a study of 27 counseling practicum students, Borders (1989a) found that students with higher levels of cognitive complexity (i.e., a higher level of ego development) reported

significantly fewer negative thoughts about clients and their performance and were better able to remain objective and neutral in the counseling sessions. A longitudinal study of cognitive development among 43 counseling students by Fong et al. (1997) found that the students' cognitive complexity increased from the beginning to the end of their counselor training program and that students with higher levels of cognitive development used more sophisticated and effective verbal skills, had more confidence in their work, and found counseling less difficult.

These studies support the importance of providing a learning environment in counselor training that facilitates learners' cognitive development, given that counselors at higher levels of cognitive development are better able to formulate a thorough, objective understanding of the client and communicate effectively and confidently in the counseling sessions. Research supports the notion that supervision is an ideal setting to promote counselors' cognitive complexity by matching supervisory interventions to each supervisee's current level of cognitive functioning and slightly mismatching those interventions such that supervisees are challenged toward more complex thinking (Borders et al., 1986; Borders, 1989a; Fong et al., 1997). Thus, it seems that the effectiveness of the learning environment within a supervision setting strongly depends upon the supervisor's ability and effort to understand each supervisee's current level of cognitive functioning and to administer supervisory interventions that are gauged upon that understanding.

**The Power Environment (PE)**

Counseling supervisors are responsible for evaluating the professional performance of their supervisees (ACA, 2014; CACREP, 2015), and this evaluative component of supervision bestows supervisors with an important source of power and interpersonal influence (Bernard & Goodyear, 2019). Evaluation and discussion of supervisees' personal challenges are inherent qualities of supervision that can provoke anxiety among supervisees, even within the best supervisory relationships (Pearson, 2000). Supervisees are often expected to discuss their vulnerabilities and disclose their fears to the same supervisors that evaluate them; such expectations may generate tension for both supervisees and supervisors, leading to potential relational conflicts (Ladany et al., 2005; Nelson & Friedlander, 2001).

Because students are emotionally vulnerable in the context of their supervision, they are in a poor position to advocate for themselves should the boundaries of that relationship break down (Jacobs, 1991). Supervisees may be hesitant to communicate their needs in supervision because of their perception that supervisors are in a position of higher authority, and that doing so could result in negative evaluation. Ladany et al. (1996) demonstrated this hesitancy by examining 108 therapists in training and investigating the nature, content, and reasons behind supervisees'

nondisclosure. They found that 97 (90%) of the supervisees had experienced at least one negative reaction to a supervisor and that most supervisees (97.2%) did not disclose their negative experiences in supervision for fear of retaliation, therefore placing supervisors in a difficult position to receive adequate feedback about their supervision performance. Thus, due to their position of authority alone, counseling supervisors may routinely be denied the benefits that formative feedback from supervisees, even if they are open to receiving it.

Nelson et al. (2008) have emphasized the importance of a strong supervisor-supervisee alliance in overcoming supervisee resistance to disclosure of supervision needs due to the power differential with their supervisor. Through a study involving interviews with 12 supervisors recognized by their professional peers as being highly competent, the researchers found that supervisors who understand the hierarchical, evaluative nature of the supervisory relationship and take purposeful steps to create a trusting supervision environment are most likely to receive honest feedback from supervisees. The specific steps to be taken by supervisors include discussing the nature and scope of their evaluative role early in the supervisory relationship, inviting feedback from supervisees regularly, being willing to acknowledge their weaknesses to supervisees, and discussing strategies with supervisees about how conflicts of perspective will be addressed. While supervisors may not be able to eliminate the imbalance of power that exists innately in the relationships with their supervisees, they can take proactive steps to lessen the deleterious effects of that power differential on the supervision environment.

Despite the essential role of the supervision environment in the development of counselors, there is a lack of research evaluating the quality of clinical supervision and a critical need for more structured and methodologically sound research (Bernard & Goodyear, 2019; Kilminster & Jolly, 2000; Wheeler & Richards, 2007). Furthermore, the quality of existing supervision research is reported as "substandard" (Ellis & Ladany, 1997, p. 492), suggesting that few conclusions can be legitimately drawn from it to inform the preparation of supervisors. Given the lack of available instruments for the evaluation of supervisors, we designed the Optimal Supervision Environment Test (OSET) to assess the supervisor's ability to create a supervisory environment that promotes counselor development.

## Method

Construction and field-testing of the Optimal Supervision Environment Test (OSET) took place in five phases. The first phase involved reviewing the relevant literature to identify important elements of supervision to serve as the basis for creating a blueprint for the OSET. The researchers defined the construct (i.e., optimal supervision environment) and distilled from the literature three essential components of an optimal supervision environment. The instrument blueprint delineated three scales

(i.e., Emotional Environment, Learning Environment, and Power Environment), each deemed to be separate but important aspects of counselor supervision. The blueprint was constructed to have equal numbers of items reflecting the three elements.

The second phase involved writing items to populate the test blueprint cells. The OSET was designed as an attitudinal measure that uses a Likert scale response format. To avoid response sets of central tendency, the items were constructed using 4-point response options, with no neutral option. Over three hundred items were written by the researchers and then edited by a recognized expert in test construction. Following this initial content review, the initial item pool was reduced to 200 items.

The third phase involved piloting the OSET with 14 doctoral students and faculty members from a counselor education program to improve the clarity of items and reduce their total number. The participants reviewed and completed the 200-item version of the OSET. Item-descriptive statistics (i.e., response frequencies, means, standard deviations, and range) were calculated to identify and modify items that were difficult to answer and to delete items that did not contribute to the instrument's variability. Using a Cronbach's Alpha reliability criterion of .80, the number of items in the instrument was reduced to 81.

In the fourth phase, an expert panel of five supervisors was used to conduct an initial assessment of OSET face and content validity. The raters were experts in the field based on their extensive research experience, scholarly research in supervision, and experience in providing supervision. The reviewers rated the 81 items based on their fit to the OSET model and overall quality; the criterion for item determination was the support of at least three of the five experts who agreed to either add, remove, or modify items. Based on the raters' responses and comments, several items were modified and eliminated, resulting in a total item pool of 78 items, with 26 items in each of the three subscales.

The fifth phase consisted of the administration of the initial OSET to a national sample of 93 counseling supervisors. As in the earlier analyses of the pilot data, an alpha coefficient of .80 was used to evaluate the internal consistency among both items in the OSET total scale and for each of the three subscales. In addition, a series of exploratory factor analyses (EFA) was used to estimate the total variance explained by the specific items, to reduce the data set into a smaller number of variables, and to reveal the underlying structure of the OSET. This analysis resulted in a final OSET composition of 15 items (5 items per subscale). The researchers submitted the final collection of 15 items to confirmatory factor analysis (CFA) to identify the initial factor structure and to estimate the construct validity of the OSET.

## Participants

The target population of this study was counselor educators and clinical supervisors across the United States, and the convenience sample was drawn from the target population. The researchers distributed an invitation to participate in the study on the CESNET listserv, which is used by counselor educators and counseling supervisors. Invitations were also distributed to university and mental health agency settings known to the researchers. The final group of participants included 93 clinical supervisors between the ages of 26 and 74 years, with a mean of approximately five years of supervisory experience. Of the 93 subjects, 31 (33.3%) were male, and 62 (66.7%) were female. Additionally, the sample included 77 (82.8%) White/European/Caucasian Americans, 10 (10.8%) African or Black Americans, two (2.2%) Asian American or Pacific Islanders, and one (1.1%) each of the following ethnic groups: Hispanic or Latino Americans, Native Americans and multiracial, and international.

Fifty-eight of the participants identified themselves as Licensed Professional Counselors (LPC), 19 as doctoral students in counselor education, three as Licensed Marriage and Family Counselors (LMFC), three as counselor educators, and 10 as others. Fifteen of the participants had less than one year of supervision experience, 41 had one to five years, 19 had six to 10 years, five had 11 to 15 years, three had 16 to 20 years, and 10 over 21 years.

## Results

### Demographics

To examine whether demographic variables (i.e., age, race, and gender) systematically affect the score of the OSET, a three-way analysis of variance (ANOVA), with age, gender, and ethnic group as independent variables, was conducted. Because of the small group sizes, the underrepresented ethnic groups were combined, resulting in two levels of race/ethnicity: Caucasian/European/White American (n = 77) and underrepresented groups (n = 16). For the purpose of analysis, age was coded into five groups: 26 to 30 years (n = 13), 31 to 40 years (n = 26), 41 to 50 years (n = 17), 51 to 60 years (n = 21), and 61 and above (n = 14). Two participants did not indicate their age in the survey. ANOVA of variance showed no significant main effects at the $p < .05$ level for age: [$F(4, 74) = 2.34$, $p = .06$], gender, [$F(1, 74) = 2.53$, $p = .146$], or race/ethnicity, [$F(1, 74) = .41$, $p = .52$]. There were also no significant interactions. Because of these results, the sample was treated as one homogeneous group, regardless of age, gender, or race/ethnicity.

### Validity

#### *Internal Structure of the OSET*

An exploratory factor analysis (EFA) was conducted using a principal component analysis (PCA) and a Varimax rotation to reduce the data set into a smaller number of variables and to reveal the underlying factor

structure of the OSET. The number of factors to be extracted was determined by eigenvalues of greater than 1.0, an inspection of the scree plot (Cattell, 1966), and extraction criteria of .40 (Kline, 2015).

The 15 OSET items were subjected to exploratory factor analysis (EFA). The significance of Bartlett's test of sphericity, [$\chi 2$ (105) = 751.76, $p < .001$], and the size of the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy, .87, showed that the 15 OSET items had an adequate common variance for factor analysis. The communalities were all above .3, further confirming that each item shared some common variance with other items.

Based on these criteria, three factors emerged with eigenvalues of greater than 1.0 after five iterations, accounting for 66.2% of the overall variance. The OSET items loaded onto three factors that correspond to Emotional Environment (EE), Learning Environment (LE), and Power Environment (PE). Each factor equally contained five items. The first factor, the EE, accounted for 23.9% of the variance, with factor loadings for this factor ranging from .77 to .82. The second factor, the LE, accounted for 20.7% of the variance with the factor loading on this factor ranging from .47 to .89. The last factor, the PE, accounted for 21.6% of the variance with factor loadings on this factor ranging from .64 to .80. The total variance was distributed approximately equally to the three factors of OSET.

**Descriptive Statistics**

Analysis of the data provided basic descriptive results of the supervisors' scores on the OSET. Overall, participants scored a mean of 52.49 (SD = 5.39). The minimum and maximum possible overall OSET scores are 15.00 and 60.00, respectively. The minimum and maximum possible subscale scores are 5.00 and 20.00. The EE scores ranged from 11.00 to 20.00, with a mean of 17.69 (SD = 2.33). The LE scores ranged from 13.00 to 20.00, with a mean of 17.58 (SD = 2.18). The PE scores ranged from 13.00 to 20.00, with a mean of 17.23 (SD = 2.18). The minimum and maximum possible scores for each OSET factor are 5.00 and 15.00, respectively. Means and standard deviations for each OSET item, as well as item-scale correlations, are shown in Table 1.

To determine the internal consistency of the OSET, Cronbach's coefficient alpha was computed on the 15 items of the OSET total scale and each of the factors derived from the exploratory factor analysis. The overall total test alpha coefficient for this sample was .90. Alpha coefficients for the three factors were .89 (Emotional Environment), .86 (Learning Environment, and .84 (Power Environment). Wasserman and Bracken (2013) suggested that scales intended for research applications should minimally be reliable at a level of .70, and preferably .80. The reliability scores for this sample were considered excellent since the reliability scores for both the overall scale and each subscale were well above the preferred .80 for scale reliability.

Overall, the reliability analyses provide support for the OSET as a reliable instrument.

Table 2 presents the intercorrelations for the OSET subscales and the total scale scores. As can be seen in Table 2, the three OSET subscales correlated to a moderate to a strong degree with the OSET total scale. Subscale to total scale intercorrelations coefficients ranged from a low .77 for EE and total scale, to a high of .85 for LE and total scale. These findings suggest that the three indices of the OSET are related but not sufficiently explained by one score alone. The results support the discriminant validity of the factor scores and suggest that interpreting the total test and the three subscales is acceptable.

**Measurement Model**

A confirmatory factor analysis was used to compare the estimate of fit for each of two measurement models: a one-factor model and a three-factor model. For the one-factor model, there was one latent variable, the Optimal Supervision Environment, which had 15 indicators. For the three-factor measurement model, three latent variables, Emotional Environment (EE), Learning Environment (LE), and Power Environment (PE), each had five indicators. The three latent variables were allowed to correlate, as shown in the correlation analyses among the factors.

The adequacy of measurement and structural model fit was based on the chi-square ($\chi 2$) statistic and several additional indices, including the minimum value of the discrepancy-C divided by the degree of freedom (CMIN/df), comparative fit index (CFI), the non-normed fit index (NNFI), and the root mean square error of approximation (RMSEA). Various cutoffs ranging from 2 to 5 have been suggested for CMIN/df. In this study, the researcher used 2.00 as the cutoff, with higher values indicating an inadequate fit (Schumacker & Lomax, 2015). In addition, values less than .06 for the RMSEA (Hu & Bentler, 1999) and values above .95 for the CFI and NNFI (Hu & Bentler, 1999) indicated a generally good fit to the data.

The two models were tested using maximum likelihood estimation. Standardized regression weights on each item were > .40, highlighting good factor loading. The hypothesized one-factor model of OSET was examined and the data showed a poor fit to the model according to the approximate fit indices: $\chi 2$ (90, N = 93) = 341.473, $p < .001$; CIM/df = 3.79; CFI = .64; NNFI = .58; and RMSEA = .17. On the other hand, the model fit statistics for the three-factor model of OSET indicated a very good fit to the data, $\chi 2$ (87, N= 93) = 116.33, p = .02; CIM/df = 1.34; CFI = .96; NNFI = .95; and RMSEA = .06. Item scores loaded strongly on the intended factor. Modification indices were inspected, and no items appeared to cross-load. Therefore, the results of fit indices for the two models suggest that the three-factor model is superior to the one-factor model. The confirmatory factor analysis also supports the interpretation of the three respective scales, as well as the total test score as an overall measure.

## Discussion

The primary purpose of this study was the construction and initial validation of the Optimal Supervision Environment Test (OSET). The five phases of scale development provided preliminary evidence of reliability and validity for the OSET. The results are largely supportive of the OSET as a scale to assess supervisors' creation of optimal supervision environments.

### Descriptions of the OSET

The OSET assesses supervisors' perceived ability to create an optimal supervision environment through three subscales: (a) the Emotional Environment (EE), (b) Learning Environment (LE), and (c) Power Environment (PE). The OSET is designed to be administered by counselor educators, supervisors, and supervisors in-training in the group or individual test administration venues. Although the OSET does not have administration time limits, the instrument can be administered in approximately five minutes. The OSET contains 15 Likert-type self-report items with four response options and no neutral option. Each subscale contains five items. Administration of the OSET results in four scores: (a) the total OSET score; (b) the EE score; (c) the LE score; and (d) the PE score. The raw scores of three subscales are combined to create the overall raw OSET score. The score for the total OSET ranges from 15 to 60; the three subscale scores range from 5 to 20.

The content of the items on the EE subscale describes the supervisor's understanding of supervisees' emotional needs and the ability to create a healthy supervisory relationship that promotes counselor development. Items on this subscale captured the notion that supervisors should initiate the supervisory relationship by appreciating the emotional needs of supervisees and creating an environment that allows supervisees to feel safe and supported. The items of the LE subscale assess supervisors' perceived ability to understand supervisees' learning needs and to intervene during supervision according to the supervisees' developmental level. Competent supervisors are skilled educators who impart their counseling knowledge and skills by matching supervision interventions according to their supervisees' cognitive developmental levels (Borders, 1989a). The PE assesses the supervisor's perceived ability to understand the hierarchical, evaluative nature of the supervisory relationship and to create an evaluative environment that promotes counselor development. Evaluation and feedback are essential roles for supervisors when monitoring the quality of professional services supervisees offer to clients. Such evaluation and feedback position the supervisor as a gatekeeper for the profession, monitoring and facilitating supervisee growth and development (Bernard & Goodyear, 2019), modeling effective feedback for supervisees (Freeman, 1985), and encouraging supervisees' self-evaluation (Farnill et al., 1997). Items on this subscale address the importance of

supervisors' provision of useful feedback and sensitive evaluation during supervision.

**Reliability**

The total scale and each OSET subscale were shown to have strong internal consistency. The OSET subscale scores had sufficient reliability for research purposes with alpha coefficients above .80 and .90 for total scales as recommended by Wasserman and Bracken (2013). The estimates of internal consistency of the total OSET and its subscales suggest that examiners can expect examinee item responses to be consistent within scales. The high alpha coefficients also suggest that the OSET will likely perform reliably in future research and training applications.

**Validity**

This study used a principal component analysis (PCA) as the exploratory factor analysis (EFA) method to examine the initial factor structure and construct validity of this scale. Based on the results of the EFA, a three-factor solution appeared to describe the dimensions of the optimal supervision environment. The final OSET contained 15 items with three subscales: the Emotional Environment (EE), the Learning Environment (LE), and the Power Environment (PE). Primary factor loadings for each of the three factors were identified, and only one of the 15 items on the OSET had a primary loading of less than .50 on its respective scale. The results of the EFA provide initial evidence in support of the OSET construct validity, in that it demonstrates an interpretable underlying factor structure that coincides with the instrument's theoretically-based blueprint.

The final factor analysis performed on the 15-item OSET had a ratio of participants to items greater than 6:1, with items per factor and the majority of factor loadings greater than .60. Only two of the 15 items' communalities were less than .60. Worthington and Whittaker (2006) suggested that smaller samples may be adequate for factor analysis if the analyses yield communalities of .60 or greater or there are at least four items per factor, and the factor loadings are greater than .60.

Concerning the total sample size for EFA, Gorsuch (1983) also recommended at least a 5:1 ratio of participants to items. This sample, therefore, satisfied Gorsuch's recommended ratio and satisfied Worthington and Whittaker's (2006) recommendation of items per factor and factor loading magnitudes. Additionally, the size of the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was good (> .60), which further supports the appropriateness of the sample for this study.

Ellis and Ladany (1997) recommended the use of confirmatory factor analysis (CFA) in instrument development and the testing of an a priori factor model in supervision research. This study satisfied their recommendations by using the CFA to test the hypothesized three-factor structure of the OSET. The results indicated that the model's goodness-of-fit with the data was good but not excellent; however, it still

satisfied all the recommended criteria. One possible explanation for a less than excellent fit is that the field study employed a relatively small sample. Because the exact sample size needed to perform a reliable CFA is not well established (Kline, 2015), it is difficult to identify the extent to which sample size affected the overall statistical fit of the model. The CFA also provided support for the multidimensionality of the supervisory construct. The three-factor model had slightly better fit indices than the alternate proposed one-factor model. These results indicate that not only does the OSET assess the nature of the optimal supervision environment, but also demonstrates that the optimal supervision environment can be viewed as a multidimensional construct.

The intercorrelations of the OSET subscales were moderate, suggesting that the three factors of the OSET are related. This result was to be expected, since they are each part of counseling supervision but not sufficiently explained by a single total test score. The results support the discriminant validity of the three-factor scores; importantly, the minor differences between the one and three-factor CFA solutions suggest that interpreting either or both, the total test and the three subscales, would be appropriate. Since the OSET was based on a comprehensive blueprint that guided instrument development, it seems likely that the three-factor structure for the OSET will also be supported with future samples of clinical supervisors.

A three-way analysis of variance (ANOVA), using supervisees' age, gender, and ethnic group as independent variables and the OSET score as a dependent variable, was conducted and found no significant effects for all independent variables. This finding demonstrates that the scale performs consistently across demographic groups, thus suggesting that the OSET scores are affected more by supervisors' ability rather than the characteristics of the participants.

## Implications for Counselor Education and Supervision

Counselor educators and supervisors need to be proactive in providing positive and meaningful supervision experiences for counselors and counseling students. The 2014 ACA Code of Ethics states that counselor supervisors, trainers, and educators have an ethical duty to promote meaningful and respectful professional relationships and to monitor client welfare, as well as supervisee performance and professional development. The three factors of optimal supervision environment (i.e., emotional, learning, and power environments) could provide clinical supervisors with a framework to understand and evaluate their supervision performance. Studies have shown that supervisors are mainly responsible for perceived negative consequences in supervision due to poor performance (Ellis, 2010; Gary et al., 2001). One of the main problems for poor supervision was that supervisors did not have a framework to monitor their supervisory performance. For example, the emotional environment can serve as an indicator that supervisors will need to provide emotional support depending on the

supervisees' counselor development level. The learning environment can help supervisors understand and promote supervisees' cognitive development by creating an effective learning environment. Supervisors also can monitor the hierarchical, evaluative nature of the supervisory relationship to create an evaluative environment that promotes counselor development. This model can be a useful framework to monitor the supervisor's ability to create an optimal supervision environment.

Counselor educators can use this model to monitor and provide feedback to training supervisors on their supervisory behaviors. Novice supervisors can use this model as a guide to understanding the core elements of supervision. This model may offer valuable information regarding the ability of novice supervisors to engage in accurate self-reflection. This model can also allow counselor educators and supervisors to help the supervisors-in-training more accurately understand their professional development.

This model looks to be an ideal model for use in future supervision research. The model can be used to build a supervision instrument using the three identified factors. An assessment can be designed to measure the supervisor's ability to create an optimal supervision environment. Counselor educators and supervisors can use this model to measure supervisory functions that work effectively and the functions that may need additional attention. It may be used as a measurement for supervisors' developmental growth as a professional.

## Conclusion

The goal of this study was to develop and evaluate the psychometric properties of the Optimal Supervision Environment Test (OSET). Results based on 93 counselor educators and clinical supervisors indicated that the instrument yields three factors: Emotional Environment, Learning Environment, and Power Environment. Sixty-six percent of the variable was explained. The OSET demonstrated high internal consistency with an overall Cronbach's alpha of .90. The three-factor model met all the model fit statistics criteria. The findings of the current study provide an important first step toward validation, but further efforts to assess the psychometric properties of the OSET are needed.

## References

American Counseling Association. (2014). *ACA code of ethics.* https://www.counseling.org/docs/default-source/default-document-library/2014-code-of-ethics-finaladdress.pdf

Bernard, J. M., & Goodyear, R. K. (2019). *Fundamentals of clinical supervision (6th ed.)*. Pearson Education.

Borders, L. D. (1989a). Developmental cognitions of first practicum supervisees. *Journal of Counseling Psychology, 36*(2), 163-169.

https://doi.org/10.1037/0022-0167.36.2.163

Borders, L. D. (1989b, August). *Learning to think like a supervisor*. Paper presented at the annual meeting of the American Psychological Association, New Orleans, LA.

Borders, L. D. (1998). Ego development and counselor development. In P. M. Westernberg, A. Blasi, & L. D. Cohen (Eds). *Personality development: Theoretical, empirical, and clinical investigations of Loevinger's conception of ego development* (pp. 331-346). Lawrence Erlbaum Associates Publishers.

Borders, L. D., & Fong, M. L. (1989). Ego development and counseling ability during training. *Counselor Education and Supervision, 29*(2)*,* 71-83. https://doi.org/10.1002/j.1556-6978.1989.tb01139.x

Borders, L. D., Fong, M. L., & Neimeyer, G. J. (1986). Counseling students' level of ego development and perceptions of clients. *Counselor Education and Supervision, 26*(1), 36-49. https://doi.org/10.1002/j.1556-6978.1986.tb00692.x

Cashwell, T. H., & Dooley, K. (2001). The impact of supervision on counselor self-efficacy. *Clinical Supervisor*, *20*(1), 39-47. https://doi.org/10.1300/J001v20n01_03

Cattell, R. B. (1966). The scree plot test for the number of factors. *Multivariate Behavioral Research, 1*, 140-161.

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*. http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

DePue, M. K., Liu, R., Lambie, G. W., & Gonzalez, J. (2020). Examining the effects of the supervisory relationship and therapeutic alliance on client outcomes in novice therapists. *Training and Education in Professional Psychology*. https://doi.org/10.1037/tep0000320

Ellis, M. V. (2010). Bridging the science and practice of clinical supervision: Some discoveries, some misconceptions. *Clinical Supervisor, 29*(1), 95-116. https://doi.org/10.1080/07325221003741910

Ellis, M. V., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 447-507). John Wiley & Sons Inc.

Farnill, D., Gordon, J., & Sansom, D. (1997). The role of effective feedback in clinical supervision. *Australian Journal of Clinical & Experimental Hypnosis, 25*(2), 155-161.

Fong, M. L., Borders, L. D., Ethington, C. A., & Pitts, J. H. (1997). Becoming a counselor: A longitudinal study of student cognitive development. *Counselor Education and Supervision, 37*(2), 100-115. https://doi.org/10.1002/j.1556-6978.1997.tb00536.x

Freeman, E. M. (1985). The importance of feedback in clinical supervision: Implications for direct practice. *Clinical Supervisor, 3*(1), 5-26. https://doi.org/10.1300/J001v03n01_02

Gibson, J. A., Grey, I. M., & Hastings, R. P. (2009). Supervisor support as a predictor of burnout and therapeutic self-efficacy in therapists working in ABA schools. *Journal of Autism and Developmental Disorders, 39*(7), 1024-1030. https://doi.org/10.1007/s10803-009-0709-4

Gorsuch, R. L. (1983). *Factor analysis* (2nd ed.). Erlbaum.

Granello, D. H. (2002). Assessing the cognitive development of counseling students: Changes in epistemological assumptions. *Counselor Education and Supervision, 41*(4), 279-293. https://doi.org/10.1002/j.1556-6978.2002.tb01291.x

Granello, D. H. (2010). Cognitive complexity among practicing counselors: How thinking changes with experience. *Journal of Counseling & Development, 88*(1), 92-100. https://doi.org/10.1002/j.1556-6678.2010.tb00155.x

Gray, L. A., Ladany, N., Walker, J. A., & Ancis, J. R. (2001). Psychotherapy trainees' experience of counterproductive events in supervision. *Journal of Counseling Psychology, 48*(4), 371-383. https://doi.org/10.1037/0022-0167.48.4.371

Hu, L., & Bentler, P. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal, 6*(1), 1-55. https://doi.org/10.1080/10705519909540118

Jacobs, C. (1991). Violations of the supervisory relationship: An ethical and educational blind spot. *Social Work, 36*(2), 30-135.

Kilminster, S. M., & Jolly, B. C. (2000). Effective supervision in practice settings: A literature review. *Medical Education, 34*(10), 827-840.

https://doi.org/10.1046/j.1365-2923.2000.00758.x

Kline, R. B. (2015). *Principles and practice of structural equation modeling* (4th ed.). Guilford Press.

Ladany, N. (2004). Psychotherapy supervision: What lies beneath. *Psychotherapy Research, 14*(1), 1-19. http://doi.org/10.1093/ptr/kph001.

Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development, 77*(4), 447-455. https://doi.org/10.1002/j.1556-6676.1999.tb02472.x

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Critical events in psychotherapy supervision: An interpersonal approach*. American Psychological Association.

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*(1), 10-24. https://doi.org/10.1037/0022-0167.43.1.10

Ladany, N., Marotta, S., & Muse-Burke, J. (2001). Counselor experience related to complexity of case conceptualization and supervision preference. *Counselor Education and Supervision, 40*(3), 203-219. https://doi.org/10.1002/j.1556-6978.2001.tb01253.x

Lovell, C. W. (1999). Empathic-cognitive development in students of counseling. *Journal of Adult Development, 6*, 195-203. https://doi.org/10.1023/A:1021432310030

Nelson, M. L., Barnes, K. L., Evans, A. L., & Triggiano, P. J. (2008). Working with conflict in clinical supervision: Wise supervisors' perspectives. *Journal of Counseling Psychology, 55*(2), 172-184. https://doi.org/10.1037/0022-0167.55.2.172

Nelson, M. L., & Friedlander, M. L. (2001). A close look at conflictual supervisory relationships: The trainee's perspective. *Journal of Counseling Psychology, 48*(4), 384-395. https://doi.org/10.1037/0022-0167.48.4.384

Pearson, Q. M. (2000). Opportunities and challenges in the supervisory relationship: Implications for counselor supervision. *Journal of Mental Health Counseling, 22*(4), 45-58.

Riggs, S., & Bretz, K. (2006). Attachment processes in the supervisory relationship: An exploratory investigation. *Professional*

*Psychology: Research and Practice, 37*(5), 558-566. https://doi.org/10.1037/0735-7028.37.5.558

Schumacker, R. E., & Lomax, R. G. (2015). *A beginner's guide to structural equation modeling* (4th ed.). Lawrence Erlbaum Associates.

Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology, 28*(1), 59-65. https://doi.org/10.1037/0022-0167.28.1.59

Wasserman, J. D., & Bracken, B. A. (2013). Fundamental psychometric considerations in assessment. In J. R. Graham & J. A. Naglieri (Eds.), *Handbook of psychology. Volume 10: Assessment psychology* (pp. 50-80). John Wiley & Sons.

Watkins, C. E. (2010). Psychoanalytic constructs in psychotherapy supervision. *American Journal of Psychotherapy, 64*(4), 393-416. http://doi.org/10.1176/appi.psychotherapy.2010.64.4.393

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counselors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research, 7*(1), 54-65. https://doi.org/10.1080/14733140601185274

White, V. E., & Queener, J. (2003). Supervisor and supervisee attachments and social provisions related to the supervisory working alliance. *Counselor Education and Supervision, 42*(3), 203-218. https://doi.org/10.1002/j.1556-6978.2003.tb01812.x

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. International Universities Press.

Worthington, R. L., & Whittaker, T. A. (2006). Scale development research: A content analysis and recommendations for best practices. *The Counseling Psychologist, 34*(6), 806-838. https://doi.org/10.1177/0011000006288127

Table 1

*Means, Standard Deviation, and Item-Scale Correlations of OSET*

| Item | M | SD | Scale Correlation |
|---|---|---|---|
| My supervisee felt “safe” during our supervisory sessions. | 3.48 | .54 | .58 |
| My supervisee interacted with me in a genuine manner. | 3.55 | .58 | .66 |
| Our supervisory relationship was characterized by a sense of mutual trust. | 3.48 | .60 | .70 |
| There was a positive atmosphere during our supervisory sessions. | 3.58 | .52 | .60 |
| My supervisee and I shared mutual respect as part of our supervisory relationship. | 3.59 | .54 | .68 |
| I was aware of and sensitive to my supervisee's training needs. | 3.49 | .50 | .67 |
| I matched my supervision approach to my supervisee's level of experience. | 3.46 | .60 | .73 |
| I tailored supervision to my supervisee’s level of competence. | 3.45 | .60 | .64 |
| I valued my supervisee's explanations about clients' behaviors. | 3.58 | .52 | .68 |
| I modeled appropriate personal and professional boundaries. | 3.59 | .52 | .66 |
| I acknowledged when my supervisee had made progress towards supervision goals. | 3.55 | .52 | .60 |
| I consistently provided evaluation feedback to my supervisee. | 3.31 | .53 | .64 |
| I was aware of and sensitive to the supervision evaluative process. | 3.47 | .54 | .63 |
| I provided evaluative feedback based on observations of my supervisee’s performance. | 3.43 | .60 | .58 |
| I regularly monitored my supervisee’s ethical behaviors. | 3.46 | .58 | .71 |

*Note.* M = mean; SD = standard deviation

Table 2

*Means and Intercorrelations for EE, LE, and PE*

| Variables | M | SD | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| 1. Emotional Environment | 17.69 | 2.33 | - | .47* | .37* | .77* |
| 2. Learning Environment | 17.58 | 2.18 | | - | .60* | .85* |
| 3. Power Environment | 17.23 | 2.18 | | | - | .81* |
| 4. Total Scale | 52.49 | 5.39 | | | | - |

*Note*. M = mean; SD = standard deviation
* $p < .01$

# *Best Practices in Multicultural Supervision in Counseling*

*The Journal of Counseling Research and Practice (JCRP)*
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**Caroline Fernandes**
**W. David Lane**
*Mercer University*

**Abstract**
The latest U.S. Census Bureau listed an increase in ethnic and racial diversity in the United States. Contributing to this are the growing statistics of refugees and immigrants whose intrapersonal experiences vary from the mainstream culture. Considering this growth, it is vital that counseling supervisors are aware of various cultures, ethnicity, social, and spiritual experiences of supervisees in training in order to provide ethical and competent supervision. This paper discusses supervisory issues, directions and trends, social justice issues, and the use of technology in multicultural supervision.

As monitored by the U.S. Census Bureau (2019), there is an immense increase in ethnic and racial diversity compared to the 1990's. This growth is projected to continue through the year 2060. As of the year 2018, approximately 327 million individuals resided in the United States, with Caucasians representing 76.6% of the total population, followed by Hispanic/Latino (18.1%), African American (13.4%), Asian (5.8%), biracial/multiracial (2.7%), and American Indian/Alaska Native (1.3%) individuals. This U.S. population census is projected to grow 78.2 million with a spike in multiracial and multi-ethnic births (Vespa et al., 2018). Considering these statistics, it is imperative that supervisors and supervisees in the counseling profession pay attention to their intrapersonal and interpersonal worldviews, beliefs, values, biases, and prejudices as they continue to work in the mental health profession (Bernard & Goodyear, 2014). Whether overtly or covertly acknowledged, race and ethnic identities are sensitive topics in the western society which need to be addressed within the supervisor-supervisee relationship. Culturally competent counselors address the cultural differences between the supervisor and supervisee to effectively strengthen their alliance (Matthews et al., 2018). With multicultural racial and ethnic awareness comes awareness of other complex issues such as sexual minority, gender issues, disability, and issues of religion and spirituality, this would help prevent clouding one's decision-making skills and avoid relying on stereotyped generalizations regarding racial-multicultural groups (Tomlinson-Clarke, 2013).

Correspondence concerning this article should be addressed to Caroline Fernandes, College of Professional Advancement, Mercer University, 3001 Mercer University Drive, Atlanta, GA 30341. Email: fernandes_cm@mercer.edu

Counselor supervision is a critical component in the continuous development of counselors' clinical skills: case conceptualization, professional identity, and therapeutic skills, including documentation and establishing ethical guidelines (Bernard & Goodyear, 2014). Therefore, it is important for supervisors to be cognizant of diverse supervisee's historical and current cultural experiences also their worldviews in order to facilitate professional growth and development (Sue & Sue, 2016). In a study Chao (2013) suggests in order for effectiveness of multicultural competencies to increase awareness, multicultural training approaches need to be based on the trainees' racial-ethnic backgrounds and experiences.

## Awareness of Multicultural Competency in Supervision

Addressing multicultural concerns in supervision respects diversity and personal experience so that the supervisor can bring out the best in the supervisee.
For example, if the supervisee is a multiracial immigrant female of color with a diverse multicultural and spiritual background who has experienced sexual and religious oppression, it would be necessary in training to validate the supervisee's intrapersonal experiences including ethnic and intrapersonal dimension of identity from her worldview (Fackling et al., 2019). As stated in the Association for Counselor Supervision and Education Task Force Report (ACES, 2019), in order to prevent ethical violation or harm to supervisees, supervisors need to be culturally competent and extra cautious of microaggression, microinvalidation, dismissive behavior, sexism, including insensitivity towards other cultures, ethnic experiences, and identity.

Moreover, it is also important for supervisors to be aware of and recognize those cultural and social norms in which educators/mentors are highly respected and trusted and seen as the expert. Supervisees from such cultures would honor guidance and mentorship by being submissive and obedient without questioning (Evans et al., 2014). If unchecked, this would add to the disproportion of power (Popejoy et al., 2020). Tomlinson-Clarke and Clark (2013, p. 4) emphasized that besides multicultural training and self-reflections to assess biases, it is important to immerse oneself in ongoing cross-cultural interactions to cultivate multicultural knowledge and cultural empathy so that helping professions recognize universal commonalities and develop appreciation for cultural uniqueness. In addition, to consider appropriate diagnosis, supervisors would need to identify and understand cultural and individual characteristics that define specific personality and life experience (Tomlinson-Clarke, 2014).

## Multicultural Issues in Supervision

Considering the growing multicultural and racial-ethnic population in the United States, it is vital for supervisors to be competent in counseling clients who are different from themselves. This will help with supervising those who are culturally different. This is especially relevant when concerns, such as stereotyping and

microaggression, or insensitivity to cultures, especially those that are not mainstream and have an undertone of intercultural variations, arise in supervision so that supervisors are fully aware and recognize when supervisees demonstrate mixed cultural values or upbringing (Bernard & Goodyear, 2014). Sue and Sue (2016), postulate the importance of multicultural competency to prevent clients from prematurely terminating counseling sessions when they feel their counselors are not able to effectively relate to their cultural values. In this case, it is easier for clients to terminate because they have the autonomy to do so, however, in the case of supervisor-supervisee relationships, it would not be that easy to terminate supervision because "the supervisee may feel obligated to continue an unsatisfactory supervisory relationship" (Fickling et al., 2019, p. 309) due to sensitive licensure documentation and State Board required strategic paperwork. Navigating these supervisor-supervisee conflict could become stressful for the supervisee due to differential of power, since the supervisor has the authority to decide whether or not the supervisee is competent to be fully licensed. Due to these insecurities, supervisees may hesitate to voluntarily terminate supervision (Glosoff & Durham, 2010). Hence, understanding the power differential in supervision, discussing differences, acknowledging cultural differences, and seeking appropriate training to bridge the gap, if any, is the responsible ethical best practice on the supervisor's part (Colistra & Brown-Rice, 2011).

Supporting this theory, Sue and Sue (2016) point out the dangers of how some graduate programs, in failing to address the issue of multicultural competency in counselor education, continue to produce inadequate supervisors who are ill-equipped to facilitate learning or the treatment of mental health issues for people of color. This observation would potentially be directed towards counseling programs that are not accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP). CACREP accreditation acts as a watchdog for academic gatekeeping in counselor education. CACREP standards emphasize the importance of thorough training in cultural competence to maintain a safe environment, conducive to learning, which supports development of professional identity, including strict standards for evaluation, practicum, and internship experiences (Council for Accreditation of Counseling and Related Education Programs [CACREP], 2019). Considering the influx of refugees and immigrants into the United States, cultural competency would not only benefit clients but would assist in keeping counseling students and supervisees safe as they learn to explore their strengths and vulnerability in counseling programs. Multicultural issues and cross-cultural issues in counseling supervision should be a priority for inclusion of supervisees from all walks of life.

## Multicultural Issues Addressed by Counseling Supervisors

According to Bernard and Goodyear (2014), supervisors are responsible for assuring that multicultural issues receive attention in supervision. It is the supervisor's responsibility to educate themselves and to address any minority groups, clients, and/or supervisee concerns that may arise (Flickling et al., 2019). Also, it is the supervisor's responsibility to ensure similarities and "myth of sameness" (Bernard & Goodyear, 1992, p. 195) do not overshadow their evaluation process or undermine cultural concerns of those different than them. Supervisors should be equipped to assist ethnic and minority supervisees by attending to their ethical and cultural concerns (ACES, 2011, p. 8). As stated by the Association for Counselor Education and Supervision Task Force (ACES, 2019), it is essential that educator, supervisors, and counselors are competent in the services they provide. The ACA Code of Ethics (2014) clearly states that supervisors must have multicultural awareness and understand the effect it has on supervisee-supervisor relationship, and that supervisors must avoid ignorance of intercultural and multicultural differences in supervision by educating themselves to be inclusive and not rely on supervisees to "bear the burden" to educate them (Fickling et al., 2019). Ignoring cultural differences in supervision is equivalent to harming the supervisor, supervisee, and client relationship triad (Bernard & Goodyear, 2014).

According to Erickson-Cornish et al. (2010), multiculturally challenging issues that may arise in supervision may take the form of unintentional "isms" and biases, overemphasizing/ underemphasizing cultural exploration during assessment, and insensitivity to supervisee's nonverbal cues and hesitation to speak. On the other hand, there are many multicultural opportunities in supervision, such as establishing mutual trust, empathy, increase in intrapersonal and interpersonal processing, and awareness of social justice and advocacy, that could contribute to supervisees' growth and development (Colistra & Brown-Rice, 2011). Supervisors could also benefit from pursuing intrinsic experiences to improve their lack of awareness (Flickling et al., 2019).

## Multicultural and Social Justice Issues

Manivong et al. (2015), stress the need for multicultural competency among counselors to evolve as society evolves due to the increasing need for social justice of the culturally diverse and marginalized clients. It is crucial to recognize the need of social justice when providing multicultural education and supervision to disenfranchised population as it is the supervisor's responsibility to be current with sociopolitical influences that impact marginalized and privileged supervisees (Flickling et al., 2019). Infusing social justice into counselor education from the beginning would be a productive format to help future counselors establish a sense of community and develop successful counseling relationships with clients and

supervisors (Decker et al., 2016; Mitcham et al., 2013). Ceballos et al. (2012), specify that empathy for human suffering and understanding is achieved when social justice is incorporated into clinical counseling. A holistic perspective during case conceptualizations helps one understand what it means to walk in someone else's shoes which includes not only assessing affective, behavioral, cognitive, and emotional development but instead viewing circumstantial problems to remove potential oppressive environmental barriers (Lewis, 2011). Furthermore, following the ACA framework would also help supervisors to better understand the multicultural, sociopolitical, religious, economic, and systemic factors that contribute to the microcosm of their supervisees (Fickling et al., 2019).

## Multicultural Issues and Cyber Supervision

The increasing use of technology in higher education and the recent COVID-19 pandemic has dramatically increased the need for cyber-supervision, "a clinical supervision of psychological services using digital tools through a synchronous audio-video format in which the supervisor is not located in the same physical location as the trainee" (Nadan et al., 2020, p. 998; Pennington et al., 2019). Research using Asynchronous (online at different times) cyber-supervision and synchronous (live online supervision) cyber-supervision has shown to promote critical thinking, inclusion, lower supervisees' anxiety, and increase a psychological sense of safety and confidence (Bender & Dykeman, 2016). During the COVID-19 pandemic online counseling and supervision has helped extend mental health support and continued supervision (Nadan et al., 2020).

Technology promotes learning and understanding of intersectionality and cultural phenomenology which stretches beyond geographical location and classrooms (Meekums et al., 2017; Pennington et al., 2019). Technology can be the bridge that creates intercultural understanding and growth; however, both supervisors and supervisees need to be cognizant of telemental health counseling ethics and ensure that professional ethical guidelines, best practices and laws are respectfully implemented (Herlihy & Corey, 2006). An additional benefit of using synchronous cyber supervision is the ability to invite competent multicultural supervisors as adjuncts into the training, allowing the supervisor to simultaneously observe and provide synchronous feedback to supervisees without interrupting the active therapeutic process (Bernard & Goodyear, 2014; Nadan et al., 2020).

In an experiential study using PractiZoom, a Zoom cyber supervision platform for practicum students, the emphasis of the study was to provide uninterrupted therapy for families during COVID-19. The Marriage and Family counseling supervisors of Barcai Institute in Israel, reported successful training and learning opportunities for their students where online ethical guidelines were clearly implemented and privacy of clients

maintained. All participants, including senior educators who were new to cyber supervision expressed positive satisfaction of this experience as use of the cyber platform was empowering and non-intrusive (Nadan et al., 2020).

## Best Practices in Multicultural Supervision

Best practices guidelines, based on evidence, provide valuable and ethical implications for supervisory competencies (Borders, 2014). The ACES Task Force report (2019) clearly states that supervisors should explore their cultural identity, values, beliefs, including issues of power and privilege with regards to counseling and supervision. Supervisors are to keep up with the latest research, scholarly literature, social, and political issues to stay relevant with current topics impacting supervisees and their clients. Code 6: a; Diversity and Advocacy Considerations (ACES, 2019), also mandates that "supervisors should recognize that all supervision is multicultural supervision" (p. 8) and that in the initial supervision session supervisors should address "issues of culture, diversity, power, and privilege" within the supervisor-supervisee counseling relationships (Guideline 6: Diversity and Advocacy; a.i., p. 8). Best practice for multicultural guidelines also includes encouraging "supervisees to raise difficult topics pertaining to social advocacy issues" to enforce open discussion and screen for explicit or implicit biases that may potentially hinder the therapeutic process (Guideline 11: The Supervisor, p. 13). Supervisors should partake in continuing education classes focused on multicultural competency, regularly self-evaluate using the Multicultural Supervision Scale, and, when in doubt, be open and willing to consult with peers whenever necessary (Guideline 11: The Supervisor, p. 13).

## Conclusion

There is no denying the face of this country has forever changed. The growth of immigrant, refugee, international students, and professional populations has contributed to the growing complexity of multiracial, multicultural, and multiethnic issues. Other issues such as physical disability, emotional, and mental health issues, need to be treated with the same awareness as multicultural issues (Colistra & Brown-Rice, 2011). The emergence of recent socio-political, racial-ethnic, social advocacy, including the growing trend of "cancel culture", where one is "canceled" or "unsupported" for their opposing viewpoint (Douglas, 2019), has forever changed the trajectory of our country. Awareness of mental health issues and the need to support multicultural mental health for minorities is rapidly growing and highlights the gap in multicultural training and development in the counseling field during this time.

Moving forward, it is imperative that graduate programs focus on inclusion and intentionally train counseling students by challenging their biases and limitations and encouraging cross cultural immersion early in the process (Barden et al., 2014; Tomlinson-Clarke, 2013; Fickling et al.,

2019). Supervisors should encourage supervisees to go deeper and explore their intrapersonal biases in order to strengthen their interpersonal relationships with clients and their professional peers (Sue & Sue, 2016). Supervisors need to increase gatekeeping to assess clinical impairment for those who resist professional and personal growth (Glance et al., 2012). Creating CACREP accredited core courses on social justice and advocacy early on in the Master's counseling education program would enhance student's awareness and promote students to be informed and ready for their practicum and internship rather than being unprepared with inadequate or limited training (Ceballos et al., 2012).

The growing awareness of multiculturalism and diversity in the United States signals a need to modify our existing cultural lens and refocus attention on professional behavior development that is holistic and inclusive. Eliminating the existing ill-prepared mental health professionals, who were the direct result of a culture-bond and biased training system (Sue & Sue, 2016), would be a great start toward a constructive direction in training mental health professionals who are inclusive and socially connected. Understanding that evidence-based practices may not always work with diverse cultural minority groups, but also understanding that they do provide a network of information one may select from and modify for implementation when needed. Considering the upward trajectory of multicultural, multiracial, and multiethnic growth in western countries, it would be beneficial to develop a synthesis of multicultural supervision models for mental health professions. Addressing intrapersonal challenges and making the covert overt would help professionals and the overall mental health system to shift, thereby creating a ripple effect of change within the political, socio-economic, educational, and spiritual paradigm of society. As discussed by Bender and Dykeman (2016), taking advantage of technology to bring the ancient knowledge of harmony and togetherness would help support a productive holistic lifestyle and would also support future generations.

## References

American Counseling Association (2014). *ACA Code of Ethics. Alexandria*, VA.

Association for Counselor Education and Supervision (2019). ACES task force report: *Best Practices in Clinical Supervision.* https://www.acesonline.net/spam-notice

Barden, S. M., Mobley, K., & Shannonhouse, L. (2014). Cultural immersion in counselor education in the United States: A quasi experimental study. *Journal of International Counselor Education, 6,* 46-60.

Bender, S., & Dykeman, C. (2016). Supervisees' perceptions of effective supervision: A comparison of fully synchronous cyber-supervision to traditional methods. *Journal of Technology in Human Services*, *34*(4), 326–337. https://doi.org/10.1080/15228835.2016.1250026

Bernard, J.M. & Goodyear, R.K. (1992). *Fundamentals of Clinical Supervision.* llyn & Bacon.

Bernard, J. M. & Goodyear, R.K. (2014). *Fundamentals of Clinical Supervision* (5th ed.). NJ Pearson Education.

Borders, L. (2014). Best Practices in Clinical supervision: Another step in delineating effective supervision practice. *American Journal of Psychotherapy*, *68*(2), 151–162. https://doi.org/10.1176/appi.psychotherapy.2014.68.2.151

Ceballos, P. L., Parikh, S., & Post, P. B. (2012). Examining social justice attitudes among play therapists: Implications for multicultural supervision and training. *International Journal of Play Therapy*, *21*(4), 232–243. https://doi.org/10.1037/a0028540

Colistra, A., & Brown-Rice, K. (2011). When the rubber hits the road: Applying multicultural competencies in cross-cultural supervision. http://counselingoutfitters.com/vistas/vistas11/Article_43.pdf

Council for Accreditation of Counseling and Related Education Programs (2019). *Introduction to the 2016 CACREP Standards*. https://www.cacrep.org/introduction-to-the-2016-cacrep-standards/

Decker, K. M., Manis, A. A., & Paylo, M. J. (2016). Infusing social justice advocacy into counselor education: Strategies and recommendations. *Journal of Counselor Preparation & Supervision, 8*(3), 100. http://search.ebscohost.com/login.aspx?direct=true&db=edo&AN=121020433&site=eds-live&scope=site

Erickson Cornish, J. A., Schreier, B. A., Nadkarni, L. I., Metzger, L. H., Henderson, & L.,Rodolfa, E. R. (2010). *Handbook of Multicultural Counseling Competencies* (1st ed.). John Wiley & Sons, Inc.

Evans, E., F. Baskerville, R., Wynn-Williams, K., & J. Gillett, S. (2014). How students' ethnicity influences their respect for teachers. *Asian Review of Accounting*, *22*(2), 159–178. https://doi.org/10.1108/ARA-01-2014-0001

Fickling, M., Tangen, J., Graden, M., & Grays, D. (2019). Multicultural and social justice competence in clinical supervision. *Counselor Education*

*and Supervision*, *58*(4), 309–316. https://doi.org/10.1002/ceas.12159

Glance, D., Fanning, G., Schoepke, A., Soto, W., & Williams, M. A. (2012). Gatekeeping in counselor education. *Vista 2014*. https://www.counseling.org/resources/library

Glosoff, H. & Durham, J. C. (2010). Using supervision to prepare social justice counseling advocates. *Counselor Education & Supervision*, *50*(2), 116–129. https://doi.org/10.1002/j.1556-6978.2010.tb00113.x

Herlihy, B. & Corey, G. (2006). *ACA Ethical Standards Casebook* (6th ed.). American Counseling Association.

Lewis, J., Ratts, M., Paladino, D., & Toporek, R. (2011). Social justice counseling and advocacy: developing new leadership roles and competencies. *Journal for Social Action in Counseling and Psychology*, *3*(1), 5–16. https://doi.org/10.33043/JSACP.3.1.5-16

Lopez, G., Ruiz, N. G., & Patten, E. (2017). Key facts about Asian Americans, a diverse and growing population. *Pew Research Center*. https://www.pewresearch.org/fact-tank/2017/09/08/key-facts-about-asian-americans/

Matthews, J. J., Mehta Barden, S., & Sherrell, R. S. (2018). Examining the relationships between multicultural counseling competence, multicultural self-efficacy, and ethnic identity development of practicing counselors. *Journal of Mental Health Counseling*, *40*(2), 129. https://doi-org.proxy-s.mercer.edu/10.17744/mehc.40.2.03

McDowell, T., Fang, S.-R., Kosutic, I., & Griggs, J. (2012). Centering the voices of international students in family studies and family therapy graduate programs. *Journal of Marital & Family Therapy*, *38*(Supp S1), 332–347. https://doi-org.proxy-s.mercer.edu/10.1111/j.1752-0606.2012.00310.x

Meekums, B., Wathen, C. C., & Koltz, R. L. (2017). Technology as a bridge: developing intercultural understanding through a counselling student videoconference. *British Journal of Guidance & Counselling*, *45*(3), 238. https://doi.org/10.1080/03069885.2015.1135875

Mitcham, M., Greenidge, W., Smith, S. D. (2013). Teaching the multicultural counseling course: Facilitating courageous conversations and transformational multicultural pedagogy. *Vistas 2013*. https://www.counseling.org/docs/default-source/vistas

Sue, D. W. & Sue, D. (2016). *Counseling the Culturally Diverse: Theory and Practice*. Wiley Publication.

Tomlinson-Clarke, S. (2013). Multicultural counseling competencies: Extending multicultural training paradigms toward globalization. *Vistas 2013*. http://www.counseling.org/knowledge-center/vistas

Tomlinson-Clarke, S. M. & Clarke, D. L. (2013). Participants' reflections of short-term cultural immersion in South Africa. Manuscript submitted for publication.

Tomlinson-Clarke, S., & Georges, C. (2014). DSM-5: A commentary on integrating multicultural and strength-based considerations into counseling training and practice. *The Professional Counselor, 4*(3), 272–281. https://doi.org/10.15241/stc.4.3.272

U. S. Census Bureau (2019). Quick facts. https://www.census.gov/quickfacts/table/PST045216/00

Vespa, J., Armstrong, D. M., & Medina, L. (2018). Demographic turning points for the United States: Population projections for 2020 to 2060. https://www.census.gov/content/dam/Census/library/publications/2018/demo/P25_1144.pdf

# *Using an Idiographic Approach to Clients with Health Anxiety*

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**Scott Peters**
**Christine D. Gonzalez-Wong**
*Texas A&M University – San Antonio*

**Abstract**
Worries about one's health, while ubiquitous, can for some become quite distressing. Health anxiety occurs when one becomes focused on symptoms and fears they may become ill or die. This often overtakes their life due to continued worry. They often spend an inordinate amount of time and effort to seek answers. Other aspects of their life are placed in the periphery or abandoned. Traditional approaches are aimed at symptom relief. While effective for some, others continue to struggle. A more novel approach that aims to look at the client both holistically and individualistically can address much more than symptom amelioration.

Counseling clients with health anxiety (HA) can be challenging. To begin, it is considered a treatment resistant condition (Ansari & Siddiqui, 2014). Additionally, many HA clients can have poor insight, often believing symptoms are attributable to a medical rather than a psychological issue (Abramowitz et al., 2010). HA drives clients to overestimate the severity of symptoms and illness (Weck & Höfling, 2014). Data suggests those with HA report lower quality of life and more functional impairment (Doherty-Torstrick et al., 2016). These factors, along with often seen co-occurring disorders (Starcevic, 2014) can make HA concerns difficult for counselors. With this in mind, the aim of the present article is to provide counselors a way of approaching clients with HA. It is hoped the approach outlined and demonstrated in the accompanying case illustration will afford counselors the confidence and competence to address health anxious clients.

## Overview of Health Anxiety

A majority of Americans regard their personal health as very important. In fact, a national survey found that almost 60% of respondents were "…paying more attention to personal health than in the past…" (Friedman, 2013). Health equates to security, the ability to care for one's self and family (Furer et al., 2007). Websites such as WebMD, MedlinePlus, and Mayo Clinic have become popular access points to address health concerns.

Correspondence concerning this article should be addressed to Scott Peters, Texas A & M University-San Antonio. Email: scott.peters@tamusa.edu

A Pew Research Center survey found more than a third of Americans used a medically focused website to explore one or more medical concerns (Fox & Duggan, 2013). Two studies conducted in Germany found about 20% of those in the general population as well as those presenting in primary care settings presented with concerns related to their health absent any physiological cause (Hiller et al., 2006; Steinbrecher et al., 2011). One's health, good or poor, is inexorably tied to relationships, occupation, income, and of course quality of life (Kansky & Diener, 2017). Furthermore, anxiety about one's health can, for some, become a significant source of distress (Sunderland et al., 2013). This chronic and persistent worry can develop in some to such an extent that it causes clinically significant distress (American Psychiatric Association [APA], 2000, 2013).

The previous iteration of the Diagnostic and Statistical Manual of Mental Disorders (DSM) listed those with having health anxiety as hypochondriasis (APA, 2000). The most recent DSM replaced hypochondriasis with two separate disorders. Illness anxiety disorder (IAD) and somatic symptom disorder (SSD) (APA, 2013). Illness anxiety disorder is characterized by excessive worry about having or developing a potentially life-threatening medical illness. Actual symptoms may or may not be present. If they are present, the symptoms are not significant. IAD results in substantial maladaptive thoughts and behaviors to address the fear of becoming ill. Some individuals with IAD may overutilize medical professionals while others may eschew medical professionals for fear of a negative report (APA, 2013). Neither of these strategies are particularly effective in addressing their distress. Additionally, IAD clients may often avoid activities they feel may exacerbate a feared illness.
Somatic symptom disorder refers to concerns associated with somatic complaints (APA, 2013). Often, there are several physical ailments. Those with SDD evaluate their symptoms as dangerous and even potentially fatal. They become preoccupied with their symptoms and perseverate on symptom meaning. Other activities may be crowded out due to excessive thoughts and persistent anxiety (APA, 2013). The prevalence rate for those with IAD is 0.1% (Newby et al., 2017). For those with SDD, it is 5% to 7% of the general population (APA, 2013). IAD and SSD are included in the section titled "Somatic Symptom and Related Disorders" in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (APA, 2013, p. 309). A diagnosis of hypochondriasis often carries significant stigma (Brakoulias, 2014). There is some thought that replacing the word hypochondriasis, as well as separating the symptomology into IAD and SSD, may lead to better understanding and possibly treatment of both (Brakoulias, 2014; Newby et al., 2017).

However, it should be noted that Newby et al. (2017) reported that IAD or SSD diagnoses share common features such as health worry, maladaptive thoughts and behaviors, chronicity, and age of onset.

Furthermore, Bailer et al. (2016) found more similarities than differences between the two disorders. Research indicated co-morbidity for IAD and SSD with panic disorder and generalized anxiety disorder for SSD (Bailer et al., 2016) and major depressive disorder (Newby et al., 2017). IAD had co-morbidity with major depressive disorder, although less so than with SSD (Bailer et al., 2016; Newby et al., 2017). Haug et al. found SSD co-morbidity with both depression and anxiety (2004) as well as HA and substance use (Jeffers et al., 2015). Furthermore, HA may be implicated in the development of obsessive-compulsive disorder (Furer et al., 2007).

Due to the overlap in symptomology of IAD and SSD, the term health anxiety (HA) will be used to refer to symptoms of either disorder for the remainder of this article. "Health anxiety is a term for mild-severe presentations of illness worries…" (Doherty-Torstrick et al., 2016, p. 391). We respect the decision to split the previous diagnosis of hypochondriasis into IAD and SSD and acknowledge the differences between the two diagnoses. However, we find the overarching distress over one's health, the impact HA has on one's level of functioning, and their quality of life to be most relevant to the present article.

**Implications of Health Anxiety**

Clients who suffer with HA can present with a variety of complaints. For example, HA clients may overutilize medical services such as emergency departments, community health clinics and their personal physicians. In fact, these individuals utilize both inpatient and outpatient services at twice the rate as those without HA (Barsky et al., 2005). Tyrer et al. (2011) found that across numerous medical disciplines, almost 20% of those presenting for medical care also demonstrated HA concerns. Additionally, the healthcare costs and service utilization for those with HA can be significant (Barsky et al., 2001; Fink et al., 2010; Lipsitt, 2015). However, for medical providers who may not able to reassure patients, this can lead to poor doctor-patient relationships (Noyes et al., 2010).

The use of the internet for health information is also significant. Almost 90% of Americans utilize the internet (Anderson et al., 2018). As mentioned previously many of those utilize health-based websites. For many, this access to health information is quick and convenient. Though for others who struggle with HA, this can be problematic. A study conducted by Doherty-Torstrick et al. found that distress actually increased during and after health-related online searches (2016b). In fact, the term cyberchondria has entered the literature related to HA (Doherty-Torstrick et al., 2016; Muse et al., 2012; Poel et al., 2016).

Paradoxically, avoidance has also been seen in those with HA (Doherty-Torstrick et al., 2016a). Specifically, HA clients may avoid activities and engage in safety behaviors to assuage anxiety and fears. Among these may be physical exertion, visiting friends who may have an illness, routine medical check-ups

(Abramowitz & Braddock, 2011; Bouman, 2014; Doherty-Torstrick et al., 2016a).

### Standard Heath Anxiety Approaches

Approaches for those suffering with IAD/SSD most cited in the literature are cognitive-behavioral therapy (CBT) (Allen et al., 2006; Barsky & Ahern, 2004; Kroenke, 2007), short-term psychodynamic (STPD) approaches (Abbass et al., 2009), exposure therapy (ET), and exposure and response prevention (ERP) (Asmundson et al., 2010; Weck et al., 2015a). Several small studies using a variety of medications have also shown some efficacy (Asmundson et al., 2010). However, CBT, STPD, ET, and ERP are based on research that assumes commonality across participants and groups. Additionally, in spite of these evidence-based approaches, many clients do not get better (Lovas & Barsky, 2010).

Empirically based approaches may not always be the best for those with complicated needs such as those with HA (Haynes & Williams, 2003). Furthermore, the aforementioned approaches are largely based upon DSM criteria for IAD and SSD alone. We assert that those with HA have other potential diagnoses that may need attention. Among these are anxiety, depression, obsessive-compulsive disorder and substance use (Jeffers et al., 2015; Starcevic, 2014; Scarella et al., 2016). Lastly, HA clients often have concerns, histories, and assets that may contribute, exacerbate, and possibly even mitigate their symptoms. These additional factors may make standard approaches inadequate for counselors working with HA. For these reasons, we think a more individualized and holistic approach may prove beneficial.

### Nomothetic Versus Idiographic Approaches

Nomothetic and idiographic approaches have been the subject of deliberation for quite some time (Salvatore & Valsiner, 2010). While it is beyond the scope of the present article to settle the debate, some basic information may prove valuable. Nomothetic knowledge and approaches focus on taking data on sample populations and generalizing it to larger populations. Essentially, those who develop, and practice nomothetic approaches seek to put a disorder into remission. In other words, these types of approaches are "disorder-focused treatments" (Persons, 2013, p. 3). Furthermore, nomothetic approaches tend to assume homogeneity, or common to all (Robinson, 2011). Most empirically supported treatments (ESTs) fall into the nomothetic category and tend to be protocol or manualized (Persons, 2013). These approaches allow for uniformity and consistency towards individual clients presenting with the same disorders. This is not to disparage them or challenge their efficacy. However, this is not to assume that nomothetic approaches are the only option or for that matter, best.

Idiographic knowledge, and hence approaches, begin from a decidedly different perspective. It is person-specific and assumes heterogeneity (Beltz et al., 2016). Idiographic refers to "…the aspects of

subjective experience that makes each person unique" (Pagnini et al., 2012, p. 1). It also explores differences within an individual over time (Beltz et al., 2016). When looking through an idiographic lens at clients and their problems, counselors can get a much more detailed and richer picture. In addition, it allows for a more tailored and client problem-specific approach as opposed to standardized approaches such as cognitive-behavioral therapy. Finally, coming from an idiographic perspective may be beneficial for clients with complex presentations. In fact, the DSM-5 states, "…case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological and biological factors that may have contributed to developing a given mental disorder" (APA, 2013, p. 19).

## Idiographic Case Formulation with Health Anxious Clients

Many struggling with HA are in persistent distress (Asmundson et al., 2010; Hiller et al., 2006). As mentioned previously, HA symptoms and their consequences can have deleterious effects on clients. As with many anxiety disorders, if not addressed the anxiety can become tenacious. Furthermore, HA clients may fuse various aspects of past, present and future, and thus have difficulty moving forward. Importantly, given the inherent differences in clients and the dynamism of client's lives, a nomothetic approach may not be the best course. We propose an idiographic approach that focuses on more than symptoms. This design permits a holistic and multidimensional picture of those with HA. This in turn allows for a very individualized approach to addressing HA clients. For clients with HA who often are defined by symptoms, an approach that examines clients from multiple perspectives may provide a less pathological and more empowering path towards wellness. Furthermore, as Bolton (2014) points out, an approach to a problem should, among other actions, "…encourage us to tell better, thicker stories" (p. 182).

## Five Ps Approach to HA

Weerasekera (1993) developed a four-factor model of case formulation for use in psychiatry. This model includes (1) predisposing, (2) precipitating, (3) perpetuating, and (4) protective factors. It examines clients from multiple perspectives; biologically, psychologically, and systemically. System, in this context, refers to "…areas outside the individual that have a significant impact on day-to-day life" (Weerasekera, 1993, p. 351-352). This approach to addressing clients encompasses the whole person, their environment, and any other factors that may impact their lives. It allows for a more dimensional view, rather than a categorical view. This multidimensional view looks at not only symptoms, but various aspects related to HA client's expressed concerns (Furer et al., 2007).

Macneil et al. (2012) expanded upon the four-factor model (Weerasekera, 1993) and developed the Five Ps. The Five Ps' approach is a short expansion on

Weerasekera's model of case formulation. It is comprised of (1) presenting problem, (2) predisposing factors, (3) precipitating factors, (4) perpetuating factors, and (5) protective factors, (Macneil et al., 2012). The addition of presenting problem as the first P works especially well with HA clients. Their singular and overriding concern is often worry over their health. This becomes the natural starting point for exploring subsequent factors. The remaining factors, along with the presenting problem, permit the counselor and client to formulate a plan of action that can be tailored to the client's needs.

In addition to symptoms, the Five Ps examines areas that can impact their symptoms and quality of life. Standard HA approaches addresses symptomology related specifically to that disorder (Persons, 2013). They may not address the previously cited co-morbid disorders. The Five Ps' approach takes a much larger view of the client. It examines several dimensions and how they intersect with, potentially contribute to, and even exacerbate clients' distress. It also explores factors that can mitigate against the anxiety of their health status and accompanying distress. Most important, this approach allows flexibility and adaptability of strategies, where most nomothetic approaches do not. Approaches such as the Five Ps has been discussed in psychiatry and psychology literature but has yet to be explored for use in counseling specific literature (Macneil et al., 2012; Persons, 2013). To better understand the Five Ps' utility for HA clients, we present the following case illustration. It shows how counselors can examine and intervene at any factor deemed relevant to clients' needs. It should be noted this particular case conceptualization is a composite of several clients who have presented with HA.

## Case Illustration

Nan is a 32-year-old married mother of two children. She presents to counseling with symptoms suggestive of health anxiety. These include intense worry and fear related to some stomach problems, fatigue, and occasional headaches. Nan has seen numerous healthcare professionals, undergone various diagnostic tests, and searched many medical websites with no answers or relief. She seems convinced there is an undiagnosed illness that if not addressed, will cause her eventual death. These concerns have caused her to curtail and at times, cease physical activities with family and friends for fear of exacerbating her health issues. Nan has gone on an extended leave of absence from her employment and has increased her alcohol consumption to alleviate her fears. Her husband and children are "fed up" and there is often tension in the home, thus exacerbating her anxiety. In fact, she often seems to be defined by her symptoms and concomitant fears.

### Presenting Problem

The presenting problem is what the client sees as currently most pressing and distressing. For Nan, it is perseverating on her health issues and fears she may become so ill that it will be too late for any medical

intervention. She has difficulty sleeping, concentrating, and her appetite has decreased. She finds it almost impossible to shake off her worries for more than a short time. The counselor validates and normalizes her concerns. The counselor then provides basic psychoeducation about anxiety such as its causes, its prevalence and some breathing techniques. The counselor allows Nan to express her worries without judgment and Nan experiences some relief as the counselor stays in the present with her.

**Predisposing Factors**

The focus here is on those aspects that may put the client at risk for developing HA. Nan has a family history of anxiety. She also reports a childhood illness that included minor complications; specifically having measles that led to nausea, vomiting, and a middle ear infection. Nan also reports a father who was very suspicious of modern medicine and often used home remedies to treat illnesses. The counselor provides some additional psychoeducation on anxiety and the hereditary and environmental links. Nan and the counselor discuss the impact of past experiences on the present and how familial influences have carried into adulthood. Nan reports that she had never considered this connection and that it helps her make sense of her experiences.

**Precipitating Factors**

Precipitating factors explores significant occurrences that preceded or triggered the presenting problem. In the case of Nan, after visiting healthcare professionals, she would seek out information on various medical websites, which would increase her anxiety and fears. She also reached out to her mother for some information on her childhood illnesses which increased her distress due to her mother's past history of anxiety and high emotionality. The counselor shares with Nan that seeking out answers to perceived health concerns can often increase the very concerns one is trying to address. Nan and the counselor discuss how her family's response can exacerbate her anxiety and Nan tells the counselor about past unhelpful conversations she has had with family members. The counselor offers to engage in some brief role plays to help Nan express to her family what she needs from them in order to freely express to them, for her, what are legitimate concerns.

**Perpetuating Factors**

Perpetuating factors are features that continue the presenting problem that are unique to each individual. For Nan, this involves isolating herself, her increased use of alcohol, her ruminations about past relatives who developed serious illnesses, and her very real fears of dying. The counselor and Nan discuss the challenges and potential implications of alcohol use. Nan reports that when she drinks, she experiences temporary relief from her health anxiety, but afterword experiences increased anxiety when she considers the potential impact on her liver. Nan and the counselor explore her isolation. Nan acknowledges the more she isolates herself, the more she

ruminates about her death and the more strained her familial relationships become. The counselor explores with Nan the transient effects of alcohol and the potential reinforcing effects of alcohol, which may actually increase her use. In addition, the counselor explores the notion of attentional bias as instrumental in her ruminations. Furthermore, the counselor uses mindfulness techniques to help Nan just 'notice' her health anxiousness and move towards valued goals. The counselor also engages in a logical analysis of the evidence that her symptoms, while real and distressing to her, leads to death.

**Protective Factors**

The counselor begins to investigate resources and/or supports that may alleviate or temper Nan's distress. The counselor inquiries about Nan's support system. Nan reports that when she spends time doing activities with her children, she does not spend as much time worrying about her health. She reports that she has a good friend that encourages her and lifts her up. Nan mentions that she wants to schedule a weekly coffee meeting with her friend to maintain and strengthen that connection. The counselor invites Nan to explore how she has overcome other anxiety-provoking situations in the past. Nan reports that after the death of a long-time friend, she found comfort in a grief support group. Nan tells the counselor that when she attended the support group, she realized how resilient she was, a strength she had not considered before. Nan considers the possibility of attending a local anxiety support group. The counselor and Nan explore previously enjoyable activities. Nan explained that she used to enjoy bicycling and the benefits she received from this activity. Nan reported that she stopped bicycling due to her fear of being in an accident and injuring herself. The counselor invites Nan to develop alternative options and Nan considers attending a stationary cycling class. Nan reports that she feels a bit hopeful as she and the counselor discuss her strengths and assets instead of perseverating on her liabilities.

**Interventions**

After addressing the 5 Ps, the counselor now has a thorough and very individualized way of conceptualizing and addressing Nan's HA. The counselor implements strategies and interventions that are tailored to Nan's experiences, allowing for flexibility in counseling sessions. It allows for movement in and across a wide variety of strategies or combining a variety of therapies (Weerasekera, 2013). The counselor considers Nan's consuming HA is amenable to an overall narrative approach. The counselor considers Nan's alcohol use and assesses the severity of her use. Nan's use indicates a slight problem and the counselor utilizes motivational interviewing techniques to address this concern. The counselor and Nan consider the possibility of a family session if familial discord persists. The strategies can be used upon completion of the Five Ps. In the case presented, strategies such as psychoeducation, acceptance and commitment therapy, and cognitive-

behavioral therapy, and solution-focused therapy could be seen.

## Discussion

### Implications for Counselors

Counselors working with HA clients may find this approach beneficial. To begin with, it allows the counselor to get both a broader and deeper picture of HA clients. While the presenting concern is likely to be the HA and symptoms, counselors can examine the various factors that contribute, exacerbate, and mitigate HA suffering. Addressing those factors many alleviate some of the HA symptoms. Highlighting the protective factors may help empower clients. Using the Five Ps approach does not require any advanced training and can be used by novice or seasoned counselors. Using the Five Ps to a challenging population such as those with HA may both increase counselor competence and counselor alliance. These are two factors positively correlated with HA outcomes (Weck et al., 2015b).

The Five Ps is very intentional in its' presentation. As each factor is explored and information shared by the client, the counselor develops a deeper, thicker and more individual picture of their client. In addition, the Five Ps allow counselors to intervene at any point and utilize a variety of strategies as they see fit to best meet the needs of their client.

### Limitations and Recommendations for Further Study

It should be noted that this approach to HA clients has not been empirically tested. Research on its efficacy and practicality would most certainly provide valuable information. A potential approach would be to initially administer a measure such as the Short Health Anxiety Inventory (SHAI)(Abramowitz et al., 2007). Once completed, then using the Five Ps as clients are engaged in counseling, they can be administered another SHAI to measure progress. Another potential area of inquiry would be to utilize the SHAI to participants and compare the Five Ps to other stand-alone interventions.

Those who struggle with HA can present challenging issues and their concerns often impact virtually every aspect of their life. HA clients have often seen numerous healthcare professionals, searched medical websites, and likely met with mental health professionals. Treating the symptoms via standard approaches such as CBT may be helpful. However, coming from an idiographic perspective allows for flexibility and modifications as necessary. It affords a way to approach the client that does not simply focus on symptoms, but the client holistically. It can be used in conjunction with any other approach. The idiographic nature of this approach may fit well with this population who are often considered very difficult to treat (Ansari & Siddiqui, 2014; Asmundson et al., 2010).

Finally, HA clients may present with additional concerns related to the current

COVID-19 pandemic. Guidelines such as mask wearing, social distancing, and attention to hygiene practices may reinforce and possibly exacerbate HA symptomology. Furthermore, the significant focus on COVID-19 via social media and the 24-hour news cycle may increase HA distress. Consequently, counselors should be mindful of these added stressors as they implement the Five Ps into their practice with HA.

## References


Abbass, A., Kisely, S., & Kroenke, K. (2009). Short-term psychodynamic psychotherapy for somatic disorders. *Psychotherapy and Psychosomatics, 78,* 265-274. doi:10.1159/000228247

Abramowitz, J. S., & Braddock, A. E. (2011). *Hypochondriasis and health anxiety.* Hogrefe.

Abramowitz, J. S., Deacon, B.J., & Valentiner, D. P. (2007). The short health anxiety inventory: Psychometric properties and construct validity in a non-clinical sample. *Cognitive Therapy Research, 31*(6), 871-883.

Abramowitz, J. S., Taylor, S., & McKay, D. (2010). *Hypochondriasis and severe health anxiety.* In D. McKay, J. S. Abramowitz, & S. Taylor (Eds.), *Cognitive-behavioral therapy for refractory cases: Turning failure into successes,* (pp. 327-346). American Psychological Association. https://doi.org/10.1037/12070-015

Allen, L. A., Woolfolk, R.L, Escobar, J. I., Gara, M. A., & Hamer, R. M. (2006). Cognitive-behavioral therapy for somatization disorder: A randomized controlled trial. *Archives of Internal Medicine, 166*(14), 1512–1518.doi:10.1001/archinte.166.14.1512

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Author.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.

Anderson, M., Perrin, A., & Jiang, J. (2018, March 5). *11% of Americans don't use the internet. Who are they?* www.pewresearch.org/fact-tank/2018/03/05/some-americans-dont-use-the-internet-who-are-they/

Ansari, K., & Siddiqui, M. (2014). A case study of hypochondriasis: Cognitive behavioral approach. *Pakistan Journal of Clinical Psychology, 13*(1), 37-45.

Asmundson, G. J. G., Abramowitz, J. S., Richter, A. A., & Whedon, M. (2010). Health anxiety: Current perspectives and future directions. *Current Psychiatry Reports, 12*(4), 306-312. doi:10.1007/s11920-010-0123-9

Bailer, J., Kerstner, T., Witthöft, M., Mier, C., & Rist, F. (2016). Health anxiety

and hypochondriasis in the light of the DSM-V. *Anxiety, Stress, & Coping, 29*(2), 219-239. doi:10.1080/10615806.2015.1036243

Barsky, A. J., Ettner, S. L., Horsky, J., & Bates, D. W. (2001). Resource utilization of patients with hypochondriacal health: Anxiety and somatization. *Medical Care, 39*(7), 705-715.

Barsky, A. J., & Ahern, D. K. (2004). Cognitive behavior therapy for hypochondriasis: A randomized controlled trial. *Journal of the American Medical Association*, *291*, 1464-1470.

Barsky, A. J., Orav, J., & Bates, D. W. (2005). Somatization increases utilization and costs independent of psychiatric and medical comorbidity. *Archives of General Psychiatry, 62*(8), 903-910. doi:10.1001/archpsyc.62.8.903

Beltz, A. M., Wright, A. G. C., Sprague, B. N., & Molenaar, P. C. M. (2016). Bridging the nomothetic and idiographic approaches to clinical data. *Assessment, 23*(4), 447-458. doi:10.1177/1073191116648209

Bolton, J. W. (2014). Case formulation after Engel—the 4P model: A philosophical case conference. *Philosophy, Psychiatry, & Psychology, 21*(3), 179-189. doi:10.1353/ppp.2014.0027

Bouman, K. T. (2014). Psychological treatment for hypochondriasis: A narrative review. *Current Psychiatry Reviews, 10*(1) 58-69.

Brakoulias, V. (2014). DSM-5 bids farewell to hypochondriasis and welcomes somatic symptoms disorder and illness anxiety disorder. *Australian and New Zealand Journal of Psychiatry, 48*(7), 688. doi:10.1177/000486741452844H

Doherty-Torstrick, E. R., Walton, K. E., Barsky, A. J., & Fallon, B. A. (2016). Avoidance in hypochondriasis. *Journal of Psychometric Research, 89,*46-52. https://doi.org/10.1016/j.jpsychores.2016.07.010

Doherty-Torstrick, E. R., Walton, K. E., & Fallon, B. A. (2016). Cyberchondria: Parsing health anxiety from online behavior. *Psychometrics, 57*(4), 390-400.doi: 10.1016/j.psym.2016.02.002

Fink. P., Ørnbøl, E., & Christensen, K.S. (2010). The outcome of health anxiety in primary care: A two-year follow-up study on health care costs and self-rated health. *PLOS ONE, 5*(3),1-12.doi: 10.1371/journal.pone.0009873

Fox, S., & Duggan, M. (2013, January 15). *One in three adults have gone online to figure out a medical condition*. http://www.pewinternet.org/2015/01/15/health-online-2013/

Friedman, L. (2013, August 1). *Americans more proactive in personal healthcare*. https://www.usatoday.com/story/news/nation/2013/08/01/personal-health-care/2605073/

Furer, P., Walker, J. R., & Stein, M. B. (2007). *Treating health anxiety and fear of death: A practitioner's guide.* Springer.

Haug, T.T., Mykletun, A., & Dahl, A. A. (2004). The association between anxiety, depression and somatic symptoms in a large population: The Hunt II study. *Psychosomatic medicine, 66*(6), 845-851. doi:10.1097/01.psy.0000145823.85658.0c.

Haynes, A. N., & Williams, A.E. (2003). Case formulation and design of behavioural treatment programs. *European Journal of Psychological Assessment 19*(3), 164–174. doi:10155759, 20030101

Hiller, W., Rief, W., & Brähler, E. (2006). Somatization in the population: From mild bodily misperceptions to disabling symptoms. *Social Psychiatry and Psychiatric Epidemiology, 41*(9), 704–712. doi:10.1007/s00127-006-0082-y

Jeffers, A. J., Benotsch, E. G., Green, B. A., Bannerman, D., Darby, M., Kelley, T., & Martin, A.M. (2015). Health anxiety and the non-medical use of prescription drugs in young adults: A cross-sectional study. *Addictive Behaviors, 50,* 74-77. doi:10.1016/j.addbeh.2015.06.012.

Kansky, J., & Diener, E. (2017). Benefits of well-being: Health, social relationships, work, and resilience. *Journal of Positive School Psychology, 1*(2), 129-169. http://journalppw.com/index.php/JPPW/article/view/20

Kroenke, K. (2007). Efficacy of treatment for somatoform disorders: A review of randomized controlled trials. *Psychosomatic Medicine, 69*(9), *881-888.* doi:10.1097/PSY.0b013e31815b00c4

Lipsitt, D.R. (2015). Hypochondriasis and somatization disorder: New perspectives. In H. Leigh & J. Streltzer (Eds.), *Handbook of consultation-liaison psychiatry* (pp. 317-333). Springer.

Lovas, D. A. & Barsky, A. J. (2010). Mindfulness-based cognitive therapy for hypochondriasis, or severe health anxiety: A pilot study. *Journal of Anxiety Disorders, 24*(8), 931-935. doi:10.1016/j.janx.dis.2010.06.019

Macneil, C. A., Hasty, M. K., Conus, P., & Berk, M. (2012). Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BMC Medicine, 10,* 111-113. doi:10.1186/1741-7015-10-111

Muse, K., McManus, F., Leung, C., Meghreblian, B., & Williams, J. M. G. (2012). Cyberchondriasis: Fact or fiction? A preliminary examination of the relationship between health anxiety and searching for health information on the Internet. *Journal of Anxiety Disorders, 26,* 189-196. doi:10.1016/j.janxdis.2011.11.005.

Newby, J. M., Hobbs, M, J., Mahoney, A. E. J., Wong, S. K., Andrews, G. (2017). DSM-5 illness anxiety disorder and somatic symptom disorder: Comorbidity, correlates, and overlap with DSM-IV hypochondriasis. *Journal of Psychosomatic Research, 101,*31-37.doi: 10.1016/j.jpsychores.2017.07.010

Noyes, R., Jr., Longley, S. L., Langbehn, D. R., Stuart, S. P., & Kukoyi, A. O. (2010). Hypochondriacal symptoms associated with a less therapeutic physician-patient relationship. *Psychiatry: Interpersonal and Biological Processes*, *73*(1), 57-69. doi:10.1521/psyc.2010.73.1.57

Pagnini, F., Gibbons, C. J., & Castelnuovo, G. (2012). The importance of an idiographic approach for the severe chronic disorders—the case of the amyotrophic lateral sclerosis patient. *Frontiers in Psychology, 3*(509), 1-2. doi:10.3389/fpsyg.2012.00509

Persons, J. B. (2013). Who needs a case formulation and why: Clinicians use the case formulation to guide decision-making. *Pragmatic Case Studies in Psychotherapy. 9*(4), 448-456. doi:10.14713/pcsp.V9i4.1835

Poel, F. T., Baumgartner, S. E., Hartmann, T., & Tanis, M. (2016). The curious case of cyberchondria: A longitudinal study on the reciprocal relationship between health anxiety and online health information seeking. *Journal of Anxiety Disorders, 43,* 32-40. doi: 10.1016/j.janxdis.2016.07.009

Robinson, O. C. (2011). The idiographic/nomothetic dichotomy: Tracing historical origins of contemporary confusions. *History and Philosophy of Psychology, 13*(2), 32-39. https://www.bps.org.uk/publications/history-and-philosophy-psychology

Salvatore, S., & Valsiner J. (2010). Between the general and the unique: Overcoming the nomothetic versus idiographic opposition. *Theory & Psychology, 20*, 817–833.

Scarella, T. M., Laferton, J. A. C., Ahern, D. K., Fallon, B. A., Barsky, A. (2016). The relationship of hypochondriasis

to anxiety, depressive, and somatoform disorders. *Psychosomatics, 57*(2), 200-207. https://doi.org/10.1016/j.psym.2015.10.006

Starcevic, V. (2014). Boundaries and overlap between hypochondriasis and other disorders: Differential diagnosis and patterns of co-occurrence. *Current Psychiatry Reviews, 10*(1), 24-33. 10.2174/1573400509666131119011010

Steinbrecher N., Koerber S., Frieser D., & Hiller, W. (2011). The prevalence of medically unexplained symptoms in primary care. *Psychosomatics, 52*(3), 263–271.

Sunderland, M., Newby, J. M., & Andrews, G. (2013). Health anxiety in Australia: Prevalence, co-morbidity, disability and service use. *The British Journal of Psychiatry, 202*(1), 56-61. https://doi.org/10.1192/bjp.bp.111.103960

Tyrer P., Cooper S., Crawford M., Dupont S., & Green J., (2011). Prevalence of health anxiety problems in medical clinics. *Journal of Psychosomatic Research, 71*(6), 392–394. doi:10.1016/jpsychores.2011.07.004

Weck, F., & Höfling, V. (2014). Assessment of implicit health attitudes: A multitrait-multimethod approach and a comparison between patients with hypochondriasis and patients with anxiety disorders. *Journal of Personality Assessment, 97*, 1-11.

Weck, F., Neng, J. M. B., Richtberg, S., Jakob, M., & Stangier, U. (2015a). Cognitive therapy versus exposure therapy for hypochondriasis (health anxiety): A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 83*(4), 665-676. doi:10.1037/ccp0000013

Weck, F., Richtberg, S., Jakob, M., Neng, J. M. B., & Höfling. V. (2015b). Therapist competence and therapeutic alliance are important in the treatment of health anxiety (hypochondriasis). *Psychiatry Research, 228*(1), 53-58. https://doi.org/10.1016/j.psychres.2015.03.042

Weerasekera, P. (1993). Formulation: A multiperspective model. *Canadian Journal of Psychiatry, 38*(5), 351-358. doi:10.1177/070674379303800513